LIFE CHIROPRACTIC PERSONAL INJURY VEHICLE COLLISION QUESTIONNAIRE

1400 King Street, # 105, Bellingham, WA 98229-6262

NAME: _____ DATE: _____

1. What was the date of the collision? _____
2. What time did the collision occur? _____
3. How many vehicles were involved in the impact? _____
4. What was the estimated damage to the vehicle in which you were riding? _____
5. In what state did the crash occur? _____
6. In what city did the collision occur? _____
7. On what street or intersection were you when the crash occurred? _____
8. In what direction were you traveling? _____
9. What type of impact was the auto collision? _____
10. Did your vehicle hit anything after the crash? If yes, describe _____
11. Where were you sitting in the vehicle during the crash? _____
12. Did you know the collision was going to happen?_____
13. In what type of vehicle (Make-Model-Year) were you riding? _____
14. What type of vehicle (Make-Model-Year) impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, can you estimate how fast the other vehicle was moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during or after the impact? -yes before/after - no before/after
19. How was your head positioned during the crash? _____
20. How was your torso positioned during the collision? _____
21. How were your hands positioned during the crash? _____
22. Did your head hit anything during the crash? -no - yes describe_____
23. Did your face hit anything during the collision? -no - yes, describe_____
24. Did your shoulders hit anything during the impact? -no - yes, describe_____
25. Did your neck hit anything during the collision? -no - yes, describe_____
26. Did your chest hit anything during the crash? -no - yes, describe_____

27. Did anything hit you during the collision? -no -yes describe what hit you and where you were struck.

28. Did your hips hit anything during the collision? -no - yes, describe_____

29. Did your knees hit anything during the impact -no - yes, describe_____

30. Did your feet hit anything during the crash? -no - yes, describe_____

31. What kind of headrest was in your vehicle?

- movable fixed headrest
- non-movable fixed headrest
- no headrest

32. Where was the headrest positioned on your head? _____

33. Did you have your seatbelt on during the impact? - yes -no

34. Did you slide out of your seatbelt during the collision? _____

35. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totaled
- side window	- front right door	
- rear window	- back left door	

36. Choose the items that dented inward

- floorboards - side door - dashboard

37. Choose the doors that would not open as a result of the accident

- front left - front right
- rear left - rear right

38. Did you go to the hospital? If no, why and do not answer 38-43 _____

39. How did get to the hospital? _____

40. What was the name of the hospital? _____

41. Were you hospitalized over night? _____

42. Circle what you were prescribed at the hospital
- pain medication - muscle relaxers - neck brace -other

43. Did you receive any stitches for any cuts at the hospital? _____

44. Were x rays taken at the hospital? If yes, which area(s) of your body? _____

45. Upon leaving the hospital, what specific instructions, if any, were you given?

SIGNATURE: _____