CAR CRASH QUESTIONNAIRE

Patient Name: ______________________________
Address: ____________________ City: ______________ PC: __________
Telephone: Home: ____________________ Work: ____________________
Date of Birth (yyyy/mm/dd): ____________________ S.I.N.: ______________
Date of injury: __________________ Time of injury: __________ AM / PM
City and street where crash occurred: ______________________________
Street (location) where crash occurred: ______________________________
What is the estimated damage to your vehicle? $ ______________________
Who made the damage estimate on your vehicle? ______________________
Were police on the scene of the accident and make a report? ○ YES ○ NO
Were charges laid? If so, against whom? ______________________________

DESCRIBE HOW THE CRASH HAPPENED:

____
____
____
____
____
____
____

COLLISION DESCRIPTION:

Check all that apply to you. You were involved in the following type of accident:

- ☐ Single-car crash ☐ Two-vehicle crash ☐ Three or more vehicles
- ☐ Rear-end crash ☐ Side crash ☐ Rollover
- ☐ Head-on crash ☐ Hit guardrail/tree ☐ Ran off road

YOUR CAR WAS STRUCK:

☐ Front ☐ Rear ☐ Driver's Side ☐ Passenger Side

YOU WERE THE:

☐ Driver ☐ Front passenger ☐ Rear passenger

DESCRIBE THE VEHICLE YOU WERE IN:

Model Year and Make: ______________________________

- ☐ Small car ☐ Mid-sized car ☐ Full-sized car
- ☐ Pick-up truck/SUV ☐ Large truck ☐ Large bus or semi-truck

DESCRIBE THE OTHER VEHICLE:

Model Year and Make: ______________________________

- ☐ Small car ☐ Mid-sized car ☐ Full-sized car
- ☐ Pick-up truck/SUV ☐ Large truck ☐ Large bus or semi-truck

ESTIMATED CRASH SPEEDS:

Estimated speed your vehicle was moving at the time of crash __________kph.
Estimated speed the other vehicle was moving at the time of crash _________kph.

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

- ☐ Slowing down ☐ Gaining speed
- ☐ Stopped ☐ Moving at a steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

- ☐ Slowing down ☐ Gaining speed
- ☐ Stopped ☐ Moving at a steady speed

DURING AND AFTER THE CRASH, YOUR VEHICLE:

- ☐ Kept going straight, not hitting anything ☐ Spun around, not hitting anything
- ☐ Kept going straight, hitting car in front ☐ Spun around, hitting another car
- ☐ Was hit by another vehicle ☐ Spun around, hitting object (not a car)
- ☐ Other______________________________

UPON IMPACT:

Which way were you thrown? ______________________________
What did you immediately feel? ______________________________

YOUR CRASH PERCEPTION:

- ☐ You were unaware of the impending collision. You did not see or hear brakes prior to impact.
- ☐ You were unaware of the impending collision and relaxed before the collision.
- ☐ You were aware of the impending collision and braced yourself.
- ☐ Your body, torso, and head were facing straight ahead.
- ☐ Your head was turned: ○ To the right ○ To the left

YES	NO	
○	○	Were you intoxicated (alcohol) at the time of collision?
○	○	Were you wearing a seatbelt? If yes, was there a shoulder harness? ____________
○	○	Were you holding onto the steering wheel at time of impact?
○	○	If you were involved in a rear end crash, did your vehicle separate away from the striking vehicle after impact? (Meaning the two vehicles pushed away from each other and did not stay attached after impact)
○	○	Did you hit your head on anything?
○	○	Did you lose consciousness? If yes, for how long? ________________
○	○	Were you able to get out of the car and walk?
○	○	Could you move all parts of your body?
○	○	Was an ambulance called for you?

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines and match left to right.

Head •	• Windshield
Side •	• Window
Shoulder •	• Side door
Arm/hand •	• Dashboard
Front chest wall •	• Knee bolster/glove compartment
Side chest wall •	• Seatbelt
Hip/abdomen •	• Frame of car near windows
Knee •	• Roof of vehicle
Leg •	• Another occupant/animal
Foot •	• Other

INDICATE IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

☐ Windshield	☐ Seat frame	☐ Knee bolster
☐ Steering wheel	☐ Side-rear window	☐ Other _______________
☐ Dash	☐ Mirror	☐ Other _______________

REAR-END COLLISIONS ONLY:

Does your vehicle have:

- ☐ Movable/adjustable head restraint
- ☐ Fixed, non-moveable head restraint
- ☐ No head restraints in the vehicle

Please indicate how your head rest was positioned at the time of collision**

- ☐ At the top of the back of your head
- ☐ Midway height of the back of your head
- ☐ Lower height of the back of your head
- ☐ Located at the level of your neck
- ☐ Located at the level of your shoulder blades (upper back) below neck

**Estimate the distance between the back of your head and the front of the headrest: _________cm

○YES ○NO Did your body (chest, face, head) hit the roof of your vehicle, steering wheel, dash, or other structure(s) within your vehicle? If yes, indicate what happened: ____
____
____

○YES ○NO Did your car separate away from the striking vehicle after the crash? If yes, indicate your estimate of the distance between the two vehicles after the crash: _________ m

ALL TYPES OF COLLISIONS

Answer this section regardless of the type of crash; indicating those relevant to your case.

YES	NO	
○	○	Did any front or side structure, such as the side door, dashboard, or floorboard of your car, dent inward during the crash?
○	○	Did the side door touch your body during the crash?
○	○	Was your hand(s) on the steering wheel or dash during the crash?
○	○	Did your body slide under the seatbelt?
○	○	Was the door(s) of your vehicle damaged to the point that you could not open it?
○	○	Have you noticed any visible bruising on your body since the accident? If yes, where? ______________________________________

WHAT HAPPENED RIGHT AFTER THE ACCIDENT?

YES	NO	
○	○	Did you go to the emergency room afterward? If yes, date and time: _______________________ City: ____________________________________ Name of the emergency room? ___________________________
○	○	Did you go to emergency in an ambulance? Name of ambulance: _______________________
○	○	Did you or another person drive to emergency room? Name of other person: ______________________
○	○	Were you hospitalized after being seen in the emergency room? If yes, how many days: ______________________
○	○	Did the ER doctor take X-rays? Indicate what regions were taken: ☐ Skull/face ☐ Shoulder, arm, or hand ☐ Neck/middle back ☐ Low back or hip/pelvis ☐ Leg or foot ☐ Collar bone ☐ Ribs/chest ☐ Other _______________
○	○	Did the hospital or clinic take MRI or CT of your body? If yes, indicate where taken: ☐ Skull ☐ Neck ☐ Low back or hip/pelvis ☐ Other________________
○	○	Did you have any broken bones/fractures? If yes, where: ___________________________
○	○	Did you have a cast put on? If yes, where: ___________________

YES	NO	
○	○	Did you have any dislocations? If yes, where:___________________
○	○	Did you have any cuts or lacerations? If yes, where: ____________ ____
○	○	Did you require any stitching for cuts? If yes, where:______________ ____
○	○	Did you have any skin abrasions? If yes, where: ________________ ____
○	○	Did you have any visible bruises or limps? If yes, where: __________ ____
○	○	Did you have any bruises along your shoulder or lap from the seatbelt?
○	○	Did the ER doctor give you pain medications?
○	○	Did the ER doctor give you muscle relaxants?
○	○	Did the ER doctor give you any other medications/prescriptions?
○	○	Were you told you had a herniated or bulging disc in your neck or back? If yes, where: ________________________________
○	○	Were you given a neck collar or back brace to wear?
○	○	Did you require any surgery after the accident? If yes, describe type and date: ________________________________
○	○	Were you hospitalized overnight? If yes, indicate dates hospitalized: ___________________________
○	○	Were you able to sleep the first night (at home or hospital)?

WHEN DID YOU NOTICE PAIN/SORENESS AFTER ACCIDENT?

☐ Immediately (less than 30 min) ☐_____ hours ☐_____ days

What discomfort did you have the first evening?___________________________
____

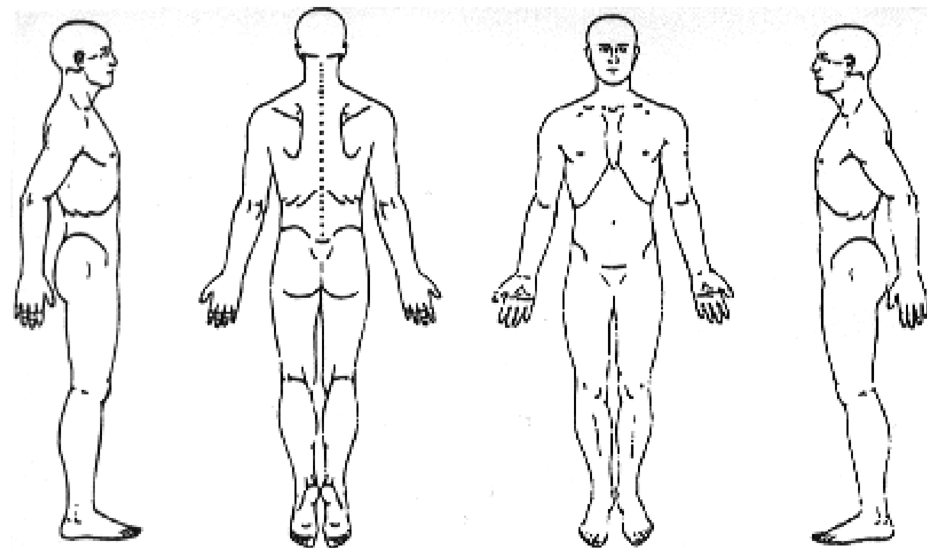
** If you had neck or back pain so severe that you were unable to get out of bed, how many hours after the accident did you develop this disabling level of pain?
____

What discomfort did you have the next day?___________________________
____

From the time of the accident, what symptoms have you experienced?_________
____
____

Please fill this out carefully. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol. Mark all affected areas, including areas of radiating pain.

Numbness == Burning XX Aching ((Pins/Needles)) Sharp |||



IF YOU <u>DID NOT</u> SEE A DOCTOR FOR THE FIRST TIME WITHIN TWO WEEKS, INDICATE WHY: (Check all that apply for your delay)

☐ No pain noticed	☐ No appointment available
☐ Thought pain was temporary	☐ No transportation
☐ Self-treated with over-the-counter drugs	☐ No insurance or money
☐ Schedule conflicts (no time)	☐ Other ___________________

HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?

○ YES ○ NO If yes, you were off work: ☐ Partially ☐ Completely
Please list all dates off work: From ________________ to ________________

List any previous Motor Vehicle Accidents (dates are important).

Accident/Injury	Date

Describe any pre-existing or unrelated conditions.
____
____
____
____

It is important for this section to be filled out in detail.

CHECK if you have had any of the symptoms listed below. Leave the row blank if the symptom listed does not apply to you.

SYMPTOMS LIST	FELT RIGHT AFTER INJURY	FELT 24-48 HOURS AFTER INJURY	HAVE SYMPTOMS NOW	HAD SIMILAR SYMPTOMS 1 to 3 MONTHS BEFORE THIS INJURY
Headache				
Dizziness				
Blurry vision				
Memory Problems				
Poor Concentration				
Irritability				
Balance Problems				
Loss of Coordination				
Sensitivity to Sound				
Sensitivity to Light				
Fatigue				
Anxiety				
Pain/Difficulty Swallowing				
Jaw Pain				
Neck Pain/Soreness				
Neck Stiffness				
Shoulder Stiffness				
Arm Pain/Tingling/Numbness				
Wrist/Hand Pain/Tingling/Numbness				
Weakness in Arms/Legs				
Upper/Mid-back pain				
Chest Wall Pain				
Low Back Pain/Soreness				
Hip Pain				
Leg Pain				
Leg Numbness/Tingling				
Pain Shoots Down Legs				
Knee Pain				
Ankle/Foot Pain				
Other				

LIST ALL THERAPISTS, DOCTORS, TESTS AND TREATMENTS SINCE INJURY
Start with the first practitioner/office/hospital you saw after your injury and check all that apply.

1

Name doctor/therapist/hospital/centre: ______________________
Address: ______________________
Date: ______________________

Indicate what was done:

- ☐ Exam consultation
- ☐ X-ray of neck
- ☐ X-ray of lower back
- ☐ Other X-rays
- ☐ MRI / CT scan
- ☐ Other diagnostic test
- ☐ Rehabilitation
- ☐ Physical therapy
- ☐ Exercises recommended
- ☐ Medication(s) prescribed
- ☐ Neck collar
- ☐ Spinal manipulation/adjustments
- ☐ Muscle massage/myotherapy
- ☐ Low back brace
- ☐ Heat packs
- ☐ Ice packs
- ☐ Ultrasound
- ☐ Other ______________

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

2

Name doctor/therapist/hospital/centre: ______________________
Address: ______________________
Date: ______________________

Indicate what was done:

- ☐ Exam consultation
- ☐ X-ray of neck
- ☐ X-ray of lower back
- ☐ Other X-rays
- ☐ MRI / CT scan
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- ☐ Low back brace
- ☐ Heat packs
- ☐ Ice packs
- ☐ Ultrasound
- ☐ Other ______________

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

LIST ALL THERAPISTS, DOCTORS, TESTS AND TREATMENTS SINCE INJURY
Start with the first practitioner/office/hospital you saw after your injury and check all that apply.

3

Name doctor/therapist/hospital/centre: ______________________________
Address: ____
Date: ______________________

Indicate what was done:

- ☐ Exam consultation
- ☐ X-ray of neck
- ☐ X-ray of lower back
- ☐ Other X-rays
- ☐ MRI / CT scan
- ☐ Other diagnostic test
- ☐ Rehabilitation
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- ☐ Neck collar
- ☐ Spinal manipulation/adjustments
- ☐ Muscle massage/myotherapy
- ☐ Low back brace
- ☐ Heat packs
- ☐ Ice packs
- ☐ Ultrasound
- ☐ Other________________________

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

LIST ALL THERAPISTS, DOCTORS, TESTS AND TREATMENTS SINCE INJURY
Start with the first practitioner/office/hospital you saw after your injury and check all that apply.

4

Name doctor/therapist/hospital/centre: ______________________________
Address: ____
Date: ______________________

Indicate what was done:

- ☐ Exam consultation
- ☐ X-ray of neck
- ☐ X-ray of lower back
- ☐ Other X-rays
- ☐ MRI / CT scan
- ☐ Other diagnostic test
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- ☐ Spinal manipulation/adjustments
- ☐ Muscle massage/myotherapy
- ☐ Low back brace
- ☐ Heat packs
- ☐ Ice packs
- ☐ Ultrasound
- ☐ Other ________________________

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

I hereby authorize Endurance on 8th Health Centre to debit my MasterCard/Visa for charges and all overdue accounts.

Card # ________ ________ ________ ________ expiry ___ /___
Credit card imprint received on______________________________

PLEASE BE AWARE THAT ALL ACCOUNTS NOT PAID BY THE INSURANCE COMPANY OR WCB BECOME THE RESPONSIBILITY OF THE PATIENT.

WE ASK THAT YOU SIGN THE SPACE BELOW IN ACKNOWLEDGEMENT AND UNDERSTANDING OF YOUR LIABILITY OF ANY COST INCURRED BY YOU AT THIS CLINIC.

SIGNATURE _________________________________
DATE_______________________