LUPO
chiropractic center

MOTOR VEHICLE COLLISION QUESTIONNAIRE
Please answer all questions completely:

1: Your name & names of additional occupant(s) of vehicle:

_____

_____

2: Who is owner of vehicle? ❑ self ❑ someone you live with ❑ other person

3: Please describe the collision in your own words:

_____

_____

4: Where did the collision occur? City/Town: _____ State: _____

5: Date of collision: _____ Time: _____ AM PM

6: Were you the: ❑ driver ❑ passenger ❑ pedestrian ❑ other _____

7: If passenger, were you in the: ❑ front seat ❑ right rear seat ❑ left rear seat

8: What type (make/model/year) of vehicle were you in? _____

9: What type (make/model/year) was the other vehicle? _____

10: Did your vehicle strike the other vehicle? ❑ yes ❑ no

11: Was your car struck by the other vehicle? ❑ yes ❑ no

12: What direction was your vehicle going? _____

13: What direction was the other vehicle going? _____

14: Was the impact from: ❑ the front ❑ the rear ❑ the left side ❑ the right side

15: What was the approximate speed at the time of the impact?

16: Your vehicle _____ mph. Other vehicle _____ mph

17: What was the weather at the time of the collision? ❑ dry ❑ wet ❑ icy

18: Was your vehicle in: ❑ park ❑ neutral ❑ in gear ❑ moving ❑ stopped

19: Were your brakes being applied? ❑ yes ❑ no

20: Was your vehicle shoved: ❑ forward ❑ backward ❑ sideways

21: Were you shoved: ❑ forward ❑ whipped backward

22: Did your seat have a head restraint (headrest?) ❑ yes ❑ no

Patient Name: _____ Date: _____

23: If yes, what was the position ❑ low ❑ mid-position ❑ high

24: Did your head ride over the headrest? ❑ yes ❑ no

25: Did your hat/glasses end up in the back seat or rear window? ❑ yes ❑ no

26: Did any other part of your body hit the interior of the vehicle? ❑ yes ❑ no

27: If yes, please specify: ❑ seatbelt restraints ❑ steering wheel ❑ dashboard
❑ windshield ❑ side door ❑ side window ❑ other _____

28: Which part of your body? ❑ chest ❑ head ❑ chin ❑ face ❑ R L knee
❑ R L shoulder ❑ R L hand ❑ other _____

29: Were you holding on to the steering wheel? ❑ yes ❑ no

30: Did you brace your arms against the dash? ❑ yes ❑ no

31: Did you brace your legs against the floorboard? ❑ yes ❑ no

32: Was your ankle turned? ❑ yes ❑ no

33: Did the vehicle go into a spin or roll as a result of the impact? ❑ yes ❑ no
If yes, explain: _____

34: How much damage was there to the outside of the vehicle? ❑ none ❑ some ❑ a lot

35: How much damage was there to the inside of the vehicle? ❑ none ❑ some ❑ a lot

36: At the point of impact, where did you experience pain? Be specific:
_____

37: Immediately after the accident were you: ❑ conscious ❑ patchy recollection ❑ unconscious

38: If you lost consciousness, how long? _____

39: Were you wearing a seat belt? ❑ yes ❑ no Did Air Bags go off? ❑ yes ❑ no

40: Did the belt have a shoulder harness? ❑ yes ❑ no
If yes, did it contribute to the pain you are experiencing? ❑ yes ❑ no

41: At the time of impact were you: ❑ looking straight ahead ❑ looking to the right
❑ looking to the left ❑ looking down ❑ looking up

42: Did the seat break as a result of the impact? ❑ yes ❑ no

43: Were you braced for the impact? ❑ yes ❑ no

44: Were you surprised by the impact? ❑ yes ❑ no

45: Did you go to the hospital? ❑ yes ❑ no

46: If yes, when? ❑ right after the accident ❑ next day ❑ other _____

47: If yes, how did you get there? ❑ ambulance other: _____

Patient Name: _____ Date: _____

48: If by ambulance, did the ambulance attendants place you in a: ❑ neck brace

❑ back brace ❑ other _____

49: Any medication or medical supplies given? _____

50: Did you have X-rays / CT Scans taken at the hospital? ❑ yes ❑ no

51: If you went to the Hospital / Urgent Care, please answer the following:

Name of Hospital / Urgent Care_____

Treatment Received _____

52: Have you had any similar problems before? ❑ yes ❑ no

If yes, explain: _____

53: Are you diabetic? ❑ yes ❑ no

54: Do you have high blood pressure? ❑ yes ❑ no

55: Do you have low blood pressure? ❑ yes ❑ no

56: Do you have arthritis or degenerative joint disease? ❑ yes ❑ no

57: What type of work do you do? _____

58: What are your job requirements? _____

59: Have you lost any days of work from this injury? ❑ yes ❑ no

If yes, give dates: _____

60: What self-care treatments at home since MVC? ❑ bed rest ❑ ice ❑ heat ❑ hot showers

❑ Rx Meds ❑ OTC Meds ❑ Ointments ❑ Other(s) _____

_____

Patient Name: _____ Date: _____

_____ Doctor Reviewed with Patient

Doctor Signature: _____ Date:_____

FOR STAFF USE ONLY: ADD'L NO-FAULT & HEALTH INS. QUESTIONS FOR PATIENT:

1. Position in accident: ❑ Driver ❑ Passenger ❑ Pedestrian ❑ Other _____
2. Was patient's vehicle At-Fault? ❑Yes ❑No If yes, what is percentage? _____
    1. If patient was passenger, was driver at fault? ❑Yes ❑No
3. Does patient have own Auto No-Fault PIP Medical Coverage? ❑Yes ❑No (Medicare Opt-out)
    1. If YES, which Auto Carrier? _____
        1. PIP Medical benefits limit? ❑$50k ❑$100k ❑$250k ❑$500k ❑no limit
        2. *(This info is found on policy declarations page, PIP medical selection (options #1 - #6)*
        3. List of "*named insureds*" on policy _____
        4. List of "*drivers*" on policy _____
    2. If NO, has Michigan Assigned Claims (MACP) application been filled out? ❑Yes ❑No
    3. Has PIP medical claim application been filed? (*not just collision claim*) ❑Yes ❑No
4. What health insurance coverage does patient have? *(check any & all ins.)*
    1. ❑ Medicare ❑ Medicaid ❑ Commercial Ins. ❑ _____
    2. Is Health Ins "Qualified"? (i.e. ≤ $6000 deductible, & pays primary to auto ins.) ❑Yes ❑No
    3. Is Health Ins through employer? ❑ Patient's work ❑ Spouse/Parent's work
5. Where does patient work? _____ ❑ Patient not working
6. Last 4 of Social Security # (for requesting records): _____

DOCUMENTS/INFO REQUESTED FOR PATIENT TO BRING TO DOCTOR (check when complete):

- ❑ No-Fault PIP Carrier name + Adjuster_____ Medical claim # _____
    - ❑ No-Fault Declarations page ❑ No-Fault PIP Medical Selection info (Options #1 - #6).
- ❑ Health Insurance cards: *("Any & All")* ie. Blue Cross, Medicare, Medicaid, etc…
- ❑ Police Report OR ❑ Patient still needs to request a copy from police dept.
- ❑ Work HR Dept contact info _____
    - ❑ Request "Full Health Plan Documents" (ERISA Summary Plan Description)
- ❑ Give patient Body Shop Questionnaire. To check safety mechanisms if car is not totaled.
- ❑ IMAGING (*previous MRIs, CT Scans, X-rays, etc*). ❑ Bring CD-ROMs & paper reports.
- ❑ List who resides in patient's household and what type of health / PIP insurance they have?

Name	Relation	Health & Auto PIP Medical Insurance:
		❑ Medicare ❑ Medicaid ❑ Commercial ❑ None ❑ Has Own PIP
		❑ Medicare ❑ Medicaid ❑ Commercial ❑ None ❑ Has Own PIP
		❑ Medicare ❑ Medicaid ❑ Commercial ❑ None ❑ Has Own PIP