

MVA QUESTIONNAIRE

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

Your position in the vehicle:

- Driver Front Passenger Passenger Third Seat (rear)
-----If passenger, your location in seat-----
 Left Middle Right Other _____

Speed of your vehicle:

- Stopped Slowing
 Parked Moving at approx _____ MPH

Collision type:

- Driver Side impact Head on Collision
 Front Impact Passenger side Impact
 Rear Impact Pedestrian incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- Full daylight
 Dawn
 Dusk
 Night

Road Conditions:

- Dry Damp Wet
 Patchy Ice/Snow
 Ice covered
 Snow covered

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility compromised by:

- Brightness Fog
 Darkness Traffic
 Rain
 Snow

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- Totally unaware that the accident was impending
 Aware that the accident was impending
 Aware that the accident was impending and braced for it

Restraints: (check all that apply)

- Seat belt
 Shoulder harness
 No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? Yes No Knocked off by impact

Was the air bag deployed?

- Car not equipped with air bag
 Air bag deployed
 Air bag not deployed

What position was YOUR headrest in?

- High position
 Middle position
 Low position

Position of YOUR head at time of impact?

- Facing straight ahead
 Tilted forward
 Rotated to the left
 Rotated to the right

Was your head thrown...?

- Backward and then forward
 Forward then backward
 To the left To the left then the right
 To the right To the right, then the left

Position of Your body at time of impact?

- Straight
 Tilted forward
 Rotated to the left
 Rotated to the right

Was your body thrown...?

- Backward and then forward
 Forward then backward
 To the left To the left then the right
 To the right To the right, then the left
 Across the vehicle

Patient Name: _____ Date: _____

Damage to vehicle YOU were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

- Outside the vehicle
- Under the vehicle

Citations:

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- Yes
- No

Immediately following the accident, did you feel...?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go...?

- Drove home
- Drove to work
- Drove to school
- Was driven home
- Was driven to work
- Was driven to school
- Drove to hospital
- Was driven to hospital
- Hospital via ambulance

Next day discomfort...?

- increased
- decreased
- same

Did your major complaints exist before the accident?

- Yes
- No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

Where did you experience pain on the day FOLLOWING the accident?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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Patient's Signature: _____

Patient Name: _____ Date: _____ 2