PRE-MVA VISIT QUESTIONNAIRE

First Name: _____

Last Name: _____

Date of the Accident (MM/DD/YYYY)**:** _____

You were:
□ The driver
□ A passenger
□ A pedestrian
□ Other (specify): _____

If you were a passenger, you were sitting in:
□ Front
□ Back left
□ Back middle
□ Back right

What happened:
□ My vehicle was rear-ended
□ My vehicle rear-ended another vehicle
□ My vehicle was T-boned at an intersection
□ My vehicle T-boned another vehicle at an intersection
□ Head on collision
□ Went off the road
□ I was pedestrian struck by a vehicle
□ Other: _____

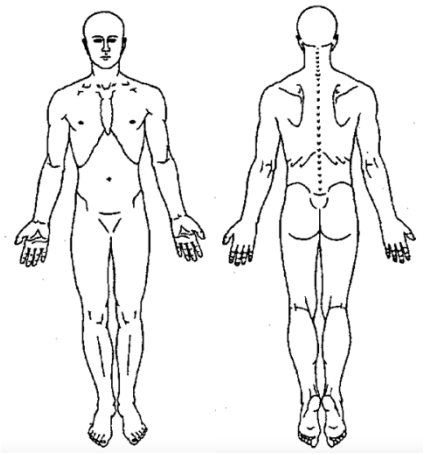
Did you have a seatbelt on?
□ Yes
□ No
□ Not applicable – Pedestrian/Other

Did the airbag deploy?
□ Yes
□ No
□ Not applicable – Pedestrian/Other

Did an ambulance take you to a hospital?
□ Yes
□ No

Have you missed work?
□ Yes
□ No

Please identify your areas of discomfort (check all that apply):
□ Head
□ Neck
□ Upper back
□ Lower back
□ Chest
□ Abdomen
□ Right arm
□ Left arm
□ Right leg
□ Left leg



Have you been in previous motor vehicle accident(s) that resulted in injuries?
□ Yes
□ No

If yes, what was the date (MM/DD/YYYY)**:** _____

If you've been in previous motor vehicle accident(s), have you fully recovered from the previous motor vehicle accident(s)?
□ Yes
□ No