Compass Chiropractic

Dr. David Krohse
P: 515.309.1217

12337 Stratford Drive
Clive, IA 50325

Mechanism of Injury Questionnaire

Name: _____ DOB: _____ Date: _____

Date of Collision: _____ Time: _____

Place: _____

Intersecting with: _____

Police Investigation by:

- ☐ Iowa State Patrol
- ☐ _____ City Police
- ☐ _____ County Police
- ☐ No investigation

Were there any witnesses? ☐ Yes ☐ No

Please describe, to the best of your knowledge, what happened during this collision:

_____

_____

_____

_____

What is the last thing you remember before the collision? _____

_____

What is the next thing you remember after the collision? _____

_____

What type of car were you in? (year, make, and model) _____

What did your vehicle impact?

- ☐ Another vehicle (year, make, model) _____
- ☐ Other – explain _____

Road conditions at time of accident: ☐ Wet ☐ Dry ☐ Icy

- ☐ Other - Describe: _____

Where were you seated in the vehicle? ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Were you:

- ☐ Aware of the approaching collision prior to impact
- ☐ Surprised by the impact

Were you wearing a seat belt? ☐ Yes ☐ No

If yes, what type? ☐ Lap belt only ☐ Shoulder and lap belt

Did you have any bruising or tenderness on your body in the area of the seatbelt following the collision? ☐ Yes ☐ No, please describe: _____

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Name: _____ DOB: _____ Date: _____

Was your vehicle equipped with headrests? ☐ Yes ☐ No

If yes, was the top of the headrest:

☐ Above the base of your skull ☐ Below the base of your skull

Was the headrest altered or damaged in the collision? ☐ Yes ☐ No

Did your head go back over the top of the headrest? ☐ Yes ☐ No ☐ Unsure

Is your car equipped with an air bag? ☐ Yes ☐ No

If yes, did the air bag activate? ☐ Yes ☐ No

If yes, did you receive any injury from the airbag? ☐ Yes ☐ No, please describe_____

_____

Did the impact to your vehicle come from the:

☐ Front ☐ Rear ☐ Right side ☐ Left side ☐ Other _____

Was your car stopped at the time of impact? ☐ Yes ☐ No

If yes, was the driver's foot on the brake? ☐ Yes ☐ No ☐ Don't know

If your foot was on the brake, was it pressing down? ☐ Slightly ☐ Moderately ☐ Strongly

If no, what was the approximate speed of your vehicle: _____ mph

If your vehicle was moving at the time of impact, was it:

☐ Slowing down ☐ Gaining speed ☐ Steady speed

Was your vehicle pushed forward from the impact? ☐ Yes ☐ No

If yes, how much?

☐ More than one car length ☐ One car length

☐ One-half car length ☐ Less than one-half car length

☐ Not at all

Did your car hit anything else after the first impact? ☐ Yes ☐ No

If yes, please describe: _____

What is the cost damage to the vehicle you were in?_____

Which of the following car parts broke during the accident?

a. Windshield _____ d. Front seat back _____

b. Right/Left side window _____ e. Other _____

c. Steering wheel _____ f. Other _____

Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No

If yes, what was its approximate speed? Approximately _____ mph

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Name: _____ DOB: _____ Date: _____

If the other vehicle was moving at the time of collision, was it:

☐ Slowing down ☐ Gaining speed ☐ Steady speed

What direction was your head pointed at the time of the collision?

☐ Right ☐ Left ☐ Forward

Name: _____ DOB: _____ Date: _____

What was the position of your hands at the time of the collision? _____

What was the position of your legs at the time of the collision? _____

Were you wearing a hat or eyeglasses at the time of the collision? ☐ Yes ☐ No

What bruises or cuts did you get from this collision?_____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

A. Head hit _____

B. Chest hit _____

C. Right shoulder hit_____ Left shoulder hit _____

D. Right arm hit _____ Left arm hit _____

E. Right hip hit _____ Left hip hit _____

F. Right leg hit _____ Left leg hit _____

G. Right knee hit _____ Left knee hit _____

H. Other _____

_____

_____

When did you first notice pain or symptoms?_____

Did the collision render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____ ☐ Don't know

Please describe how you felt immediately after the collision:_____

_____

_____

Have you gone to a hospital? ☐ Yes ☐ No Hospital: _____

If yes, when did you go? _____

How did you get there? _____

What parts of your body were x-rayed? _____ ☐ None

What treatment did you receive? _____

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Name: _____ DOB: _____ Date: _____

Have you been treated by any other doctor or health professional? ☐ Yes ☐ No

If yes, Name_____ City _____

Recommendation and or treatment received_____

_____

How long were you treated? _____

Name_____ City _____

Recommendation and or treatment received_____

_____

How long were you treated? _____

What medication did you take for your injuries? _____

Are you still taking them?

☐ Yes Do they help? ☐ Yes ☐ No ☐ Don't know

☐ No How long did you take them? _____

Why did you quit? _____

Have you lost time from work as a result of this injury?

☐ Yes, give dates: _____

☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

If yes, describe restrictions _____

Indicate the symptoms that are a result of this collision:

☐ Dizziness	☐ Difficulty sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/shoulder pain	☐ Low back pain
☐ Headaches	☐ Fatigue	☐ Numb hands/fingers ☐ Right ☐ Left ☐ Both	☐ Low back stiffness
☐ Blurred vision	☐ Tension		☐ Leg pain ☐ Right ☐ Left ☐ Both
☐ Buzzing in ear	☐ Depression	☐ Mid back pain	
☐ Ringing in ear	☐ Neck pain	☐ Chest pain	☐ Numb feet/toes ☐ Right ☐ Left ☐ Both
☐ Loss of balance	☐ Neck stiffness	☐ Stomach upset	

☐ Other _____

_____

Is your condition:

☐ improved ☐ unchanged ☐ getting worse ☐ constant ☐ comes and goes

Patient Signature: _____

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Insurance Information

Name: _____ DOB: _____ Date: _____

Please list all insurance companies you are insured with:

Automobile Insurance

Name of insurance company _____

Agent's name _____ Phone number _____

Policy holder's name _____ Policy number _____

Claim number _____

Health Insurance

Name of insurance company _____

Policy holder's name _____ Policy number _____

Employer _____ SS# _____

Other _____

_____

The following questions pertain to the other vehicle involved in the accident:

Name of Driver _____ Phone number _____

Address _____

Insurance company _____

Agent's name _____ Phone number _____

Have you retained an attorney? ☐ Yes ☐ No

If yes, whom? _____

_____

Phone number: _____