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ONTO ORTHOPEDICS
Specialists in motion

MVA Questionnaire

Patient Name:_____ Date:_____

1. What was the date of the accident?
2. What kind of car was patient in? (year, make, & model)
3. Where was the patient in the car? (Driver, front seat passenger, etc.)
4. What kind of collision was it? (Rear-end, frontal, side impact, etc.)
5. At what estimated speed was the patient's vehicle traveling at time of impact?
6. At what estimated speed was the other vehicle traveling?
7. What kind of car hit the patient's vehicle?
8. What was time of day & road conditions at time of accident?
9. Was patient wearing seat belt?
10. Did the airbag in the patient's car deploy?
11. What was the patient's head/body position at time of impact? (Hands on wheel? Head turned toward one side?)
12. Were there any second collisions inside the vehicle? (Did the impact push the patient's vehicle into another car, a guardrail or construction barrel, etc.)
13. How did the patient feel right after the accident? (Dizzy, disoriented, nauseated, scared, headache, etc.)

14. Did the patient experience any immediate pain or loss of consciousness after the accident?

15. When did symptoms first appear?

16. Were the police and/or ambulance called to the scene? Was a police report filed? If so, who was ticketed?

17. Was the patient transported to the hospital by the ambulance, or did the patient take himself/herself to the hospital later? If so which hospital?

18. Is there an estimated amount of damage done to the patient's vehicle? (If no monetary value, then was the damage mild, moderate, or severe?)

19. Do you have the motor vehicle insurance information? If so please provide.