



Davis Spine & Orthopaedics

Spine and Orthopaedic Surgeon
Board Certified and Fellowship Trained

www.DavisSpine.com
2800 Windguard Circle Suite 101
Wesley Chapel, FL 33544

Phone: 813-994-BACK (2225) Fax: 813-438-4494

Motor Vehicle Accident Questionnaire

Patient's name: _____ DOB: _____

Date of accident: _____

I was: _____ The Driver _____ A Passenger _____ In the back seat

I was: _____ Belted _____ Not belted

Did the airbags deploy? _____ Yes _____ No

Did you lose consciousness? _____ Yes _____ No

How fast were you going? _____

How fast was the other driver going? _____

How many people were in the vehicle with you? _____

How much damage was done to your vehicle?

No damage Small amount of damage Medium amount of damage Large amount of damage Totaled

Did you go the ER? _____ Yes _____ No

Briefly describe the incident: _____

Have you seen any other doctor's for this incident?

_____ Yes _____ No Who did you see? _____

When did you see this doctor? _____

After the incident, when did your symptoms first start?

_____ Immediately _____ Hours later (how many?) _____ _____ Days later (how many?) _____

_____ Other: _____

Where did you feel pain immediately after the incident? _____

Since the injury, are your symptoms: ___ Same ___ Improving ___ Worse

Have you ever had the same symptoms before your current accident? ___ No ___ Yes

If yes, please explain: _____

Mention any activity limitations you are experiencing since the incident: ___ None

Have you had any prior accidents? ___ Yes ___ No

If yes, that was the date of the previous accident? _____

Have your symptoms from the previous accident resolved? ___ No ___ Yes