Accident History Questionnaire

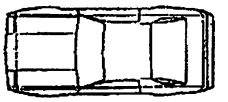
PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

Address _____ Phone Number _____

Cell Phone _____ Email _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____ 4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car. _____
   Year & Model of other car. _____
7. What was the approximate damage done to your car? $ _____
8. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other: _____
9. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark ☐ other (describe): _____
10. Where was your car struck?

FRONT  REAR

In your own words, please describe accident: _____

_____

_____

11. Type of Collision: ☐ Head-on ☐ Broad-side ☐ Front Impact ☐ Rear-end car in front ☐ Rear impact ☐ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

_____

13. Did you see the accident coming? ☐ yes ☐ no → 14. Did you brace for impact? ☐ yes ☐ no
15. Were seatbelts worn? ☐ yes ☐ no → 16. Were shoulder harnesses worn? ☐ yes ☐ no
17. Does you car have headrests? ☐ yes ☐ no
18. If yes, what was the position of those headrests compared to your head before the accident?
    ☐ Top of headrest even with **bottom** of head ☐ Top of headrest even with **top** of head
    ☐ Top of headrest even with **middle** of neck
19. Was your car braking? ☐ yes ☐ no → 20. Was your car moving at the time of the accident? ☐ yes ☐ no
21. If yes, how fast would you estimate you were going? _____ mph → 22. the other car? _____ mph
23. Head/Body position at the time of impact:
    ☐ Head turned left/right ☐ Head looking back ☐ Head straight forward
    ☐ Body straight in sitting position ☐ Body rotated right/left ☐ Other:
24. As a result of the accident you were:
    ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other:
25. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
26. Were you wearing a hat or glasses? ☐ yes ☐ no
27. Could you move all parts of your body? ☐ yes ☐ no
28. If no, what parts couldn't you move and why? _____
29. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
30. If no, why not? _____
31. Did you get any bleeding cuts? ☐ yes ☐ no If yes, where? _____
32. Did you get any bruises? ☐ yes ☐ no If yes, where? _____
33. Describe how you felt immediately after the accident: _____
    Later that day: _____
    The next day: _____

34. Check symptoms apparent since the accident:

☐ Headache	☐ Chest pain	☐ Neck pain/Stiffness	☐ Mid back pain	☐ Light sensitivity
☐ Anxious/Nervousness	☐ Pain behind eyes	☐ Dizziness	☐ Low back pain	☐ Sleeping problems
☐ Numbness in fingers	☐ Loss of smell	☐ Numbness in toes	☐ Fainting	☐ Cold feet
☐ Facial Pain	☐ Loss of memory	☐ Fatigue	☐ Breath shortness	☐ Loss of taste
☐ Irritability	☐ Depression	☐ Ringing/Buzzing	☐ Cold Sweats	☐ Loss of balance
☐ Tension	☐ Constipation	☐ Cold hands	☐ Clicking / Popping Jaw	
☐ Diarrhea	☐ Other_____			

35. Occupation:_____ 36. Employer:_____

37. Have you missed time from work: ☐ yes ☐ no

38. If yes, full time off work: _____to_____

39. If yes, part time off work: _____to_____

40. Did you seek medical help immediately after the accident? ☐ yes ☐ no

41. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone drove me ☐ Drove myself ☐ Other:_____

42. Doctor #1: Name: _____ 43. First Visit Date: _____

44. Were you examined? ☐ yes ☐ no 45. Were X-rays taken? ☐ yes ☐ no

46. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars

47. If yes, what kind of treatment did you receive?_____

48. What benefits did you receive from the treatment?_____

49. Date of last treatment? _____

50. Doctor #2: Name:_____ 51. First Visit Date:_____

52. Were you examined? ☐ yes ☐ no 53. Were X-rays taken? ☐ yes ☐ no

54. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars

55. If yes, what kind of treatment did you receive?_____

56. What benefits did you receive from the treatment?_____

57. Date of last treatment:_____

58. Do you have an attorney on this claim? ☐ yes ☐ no

59. If yes, who? _____

Address_____

City_____ State _____ Zip _____ Phone _____

Illustrate how the accident happened.

PAST MEDICAL HISTORY: Place an (X) if it applies and describe.

☐ None related to current complaints ☐ Hospital or operation ☐ Auto Accident ☐ Work Accident ☐ Illness ☐ Other

Describe _____

_____

SECTION 4: WALKING

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5: SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6: STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it causes extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7: SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8: SEX LIFE

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9: SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10: TRAVELING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to the journeys of less than one hour.
- ☐ Pain restricts me to short necessary trips under a 1/2 hour.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

CURRENT CHIEF COMPLAINTS:

Place an (X) in the appropriate complaint areas.

SPINE

☐ Low back ☐ Mid back ☐ Neck ☐ Pelvis

UPPER EXTREMITY

☐ Shoulder R/L ☐ Arm R/L ☐ Elbow R/L
☐ Wrist R/L ☐ Forearm R/L ☐ Hand R/L

LOWER EXTREMITY

☐ Hip R/L ☐ Thigh R/L ☐ Knee R/L
☐ Leg R/L ☐ Ankle R/L ☐ Foot R/L

OTHER (describe): _____

SUBJECTIVE PAIN LEVEL:

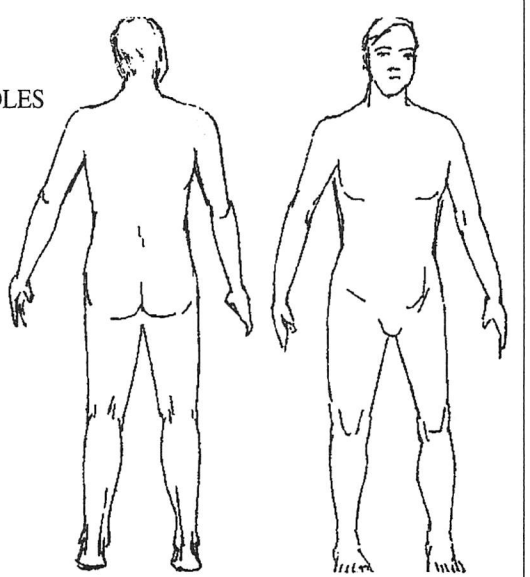
On a scale of 1 - 10, place an (X) in your current pain level

NORMAL **EMERGENCY**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7 8 9 10

Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

× NUMBNESS
\+ BURNING
○ PIN & NEEDLES
= STABBING



Patient's Signature