Accident History Questionnaire

Patient Name____ **Date**____________________

Accident Information: Date of accident____________________ time of day ______________ AM/ PM
Driver of car________________________________ Who owns car______________________________
How many people in vehicle with you? ______________________ In other car?__________________
Road conditions: [ ] dry [ ] rainy [ ] very wet [ ]snow [ ] slick/ oil [ ] Other______________________
Visibility: [ ] clear [ ] foggy [ ] smokey [ ] bright [ ] dusk [ ] dark [ ] Other______________________
Were police called to scene? [ ]Yes [ ]No **Was accident report filed?**[ ]Yes [ ]No **Who was cited**________________

Insurance Information: Have you contacted your automobile insurance company? [ ] NO [ ] YES
Automobile Insurance company:______________________________ Adjuster name________________
Policy number______________________________ Claim number______________________________
Health Insurance Name______________________________ **(please give card)** [ ] No health insurance
Do you have an Attorney? [ ] NO [ ] YES- Name___________________________ Phone______________

Describe accident in your own words:____
____
____

Vehicle you were in:
Description: [ ] car [ ]truck [ ]van [ ]bus [ ]SUV [ ] other__________ Size: [ ]compact [ ]mid-size [ ]full size
Your position in vehicle: [ ] driver [ ] front passenger [ ] rear passenger [ ] center bench [ ] pedestrian
Your vehicle was: [ ] at complete stop [ ] slowing to stop [ ] traveling – what speed ________MPH
Your vehicle was: [ ] rear-ended [ ] hit head on / front [ ] hit side/ T-boned [ ] side swiped [ ] hit pole/ wall
[ ] spun out of control [ ] if rear-ended did the force cause you to collide with other vehicle
Your vehicle sustained: [ ] minimal damage [ ] mild damage [ ] moderate damage [ ] severe damage / totaled

Other Vehicle:
Description: [ ] car [ ]truck [ ]van [ ]bus [ ]SUV [ ] other___________ Size: [ ]compact [ ]mid-size [ ]full size
How fast was other vehicle traveling? [ ] unsure [ ] ______MPH **Did they attempt to brake?** Yes No Unsure
Other vehicle sustained: [ ] minimal damage [ ] mild damage [ ] moderate damage [ ] severe damage / totaled

Patient information at time of impact:
Where you prepared for impact? [ ] complete surprise [ ] aware of accident coming [ ] braced for impact
Did you have seat belt on? [ ] none [ ] lap/ shoulder harness [ ] lap belt only [ ] shoulder harness only
Headrest was: [ ] even with head [ ] above head [ ] below base of head [ ] unsure [ ] no headrest in car
Position of your head: [ ] looking straight [ ] turned right [ ] turned left [ ] looking down [ ] looking at mirror
Position of body: [ ] straight [ ] rotated left [ ] rotated right [ ] bending down [ ] reaching for radio
Airbags: [ ] did not deploy [ ] did deploy [ ] car has none **Feet position:** [ ] on brake [ ] slipped off brake

Did any part of your body hit or strike any part of the vehicle? Explain_____________________________
____
Did you lose consciousness? [ ] no [ ] yes (how long_______) [ ] unsure [ ] no, but felt dazed and confused
When did you first notice symptoms? [ ] instantly [ ] later that day [ ] the next day [ ] days later [ ]weeks later

Patient name:____ **Date**______________________

Symptoms you noticed after the accident: (check all that apply)

[ ] headache [ ] neck pain [ ] back pain (middle / lower) [ ] arm pain (right / left) [ ] leg pain (right / left)
[ ] dizziness [ ] fainting [ ] chest pain [ ] numbness or tingling- where__________________________
[ ] hip pain [ ] knee pain [ ] ankle pain [ ] foot pain [ ] shoulder pain [ ] elbow pain [ ] wrist/ hand pain
[ ] shortness of breath [ ] loss of balance [ ] ringing in ears [ ] blurred vision [ ] constipation / diarrhea
[ ] can't hold urine [ ] convulsions / seizures [ ] nervousness [ ] poor memory [ ] insomnia [ ] fainting
Did you get any cuts or bruises? ____
Do you have any swelling anywhere?____

Medical Care:

Did you seek medical care after the accident? [ ] No [ ] Yes – where_______________________________
When did you go? [ ] N/A [ ] immediately [ ] later same day [ ] next day [ ] other______________________
How did you get there? [ ] N/A [ ] ambulance [ ] drove self [ ] family drove [ ] friend drove
What treatment was given? [ ] N/A [ ] x-rays [ ] medications [ ] CT scan [ ] MRI [ ] stitches [ ] brace
Where you referred anywhere? [ ] N/A [ ] Chiropractor [ ] Physical therapy [ ] orthopedic [ ] neurologist
Have you seen any other physicians other than ER doctor? [ ] NO [ ] YES- Who_______________________
____
Any other treatments other than ER? [ ] NO [ ] YES- describe_______________________________________
____

Work History:

Are you employed? [ ] NO [ ] disabled [ ] YES - { } full time { } part time { } per diem [ ] Other__________
Occupation: _____________________________________ Employer:____
<u>Have you missed time from work due to accident/ injuries?</u> [ ] NO [ ] YES if yes-
Missed: [ ] restricted full duty from __________ to ___________ Missed __________ days / weeks/ months
[ ] restricted light duty from __________ to ___________ Missed __________ days / weeks/ months
How does your injuries affect you ability to work? ____
____

Have you injuries/ pain affected ability to do other activities? [ ] NO [ ] YES- if yes mark all that apply:
[ ] housework [ ] sleep [ ] exercise [ ] golf [ ] sexual activity [ ] walking [ ] driving [ ] traveling
[ ] sitting [ ] lifting [ ] bending [ ] climbing stairs [ ] opening jars [ ] yard work [ ] hobbies [ ]____________

Have you had previous accidents or injuries? [ ] NO [ ] YES- Describe____________________________________
____

Have you had previous surgeries? [ ] NO [ ] YES- describe____
____

Did you consider yourself to be in good health prior to this accident? [ ] NO [ ] YES

The above information is true and accurate to the best of my knowledge.

Patient Signature____ **Date**____________________