

Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

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 the 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?



In your own words, please describe accident: _____

11. Type of Accident: Head-on collision Broad-side collision 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 your 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. How fast would you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
 Head turned left/right Body straight in sitting position
 Head looking back Body rotated right/left
 Head straight forward 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. Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

34. Check symptoms apparent since the accident:

Headache

Neck pain/Stiffness

Mid back pain

Eyes Light Sensitive

Pain Behind Eyes

Dizziness

Fainting

Sleeping problems

Numbness in fingers

Numbness in toes

Loss of smell

Loss of taste

Loss of memory

Fatigue

Breath shortness

Irritability

Depression

Ringing/Buzzing

Loss of balance

Tension

Cold hands

Cold feet

Diarrhea

Constipation

Chest pain

Nervousness

Cold Sweats

Anxious

Facial Pain

Clicking or Popping Jaw

Low Back Pain

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 else drove me

Drove own car

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

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 below 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 _____

Family History: Place an (X) if any family member has suffered from:

Tuberculosis Kidney Disease Spinal Disorder

Mental Illness Epilepsy Diabetes

Gout Allergy Arthritis

Hypertension Cancer Migraines

Heart Attack Other, list: _____

Personal History: Place an (X) if it applies, describe.

Single Married Divorced Separated Widow/Widower

Number of Children _____ Number of Children at home _____

Employed Spouse yes no

Are you pregnant? yes no not sure

Medications, describe _____

Disease, describe _____

Other, describe _____

SYSTEM REVIEW Place an (X) next to the symptoms you know you have

Genito-Urinary System

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Gastro-Intestinal System

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nervous System

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Genito-Urinary System

<input type="checkbox"/> Bladder trouble	<input type="checkbox"/> Excessive urination	<input type="checkbox"/> Scanty urination
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Discolored urine	<input type="checkbox"/>

Gastro-Intestinal System

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Difficult chewing
<input type="checkbox"/> Difficult swallowing	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting food	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation	<input type="checkbox"/> Black stool	<input type="checkbox"/> Bloody stool
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Liver trouble	<input type="checkbox"/> Gall bladder trouble
<input type="checkbox"/> Weight trouble	<input type="checkbox"/>	<input type="checkbox"/>

Nervous System

<input type="checkbox"/> Numbness	<input type="checkbox"/> Loss of feeling	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Headaches
<input type="checkbox"/> Muscle jerking	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Confusion	<input type="checkbox"/> Depression	

Directions: This questionnaire has been designed to give the doctor information as to

Cardio-Vascular System

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Pain over heart	<input type="checkbox"/> Difficult breathing
<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Coughing phlegm	<input type="checkbox"/> Coughing blood
<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Lung problems	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Other

Eye, Ear, Nose and Throat System

<input type="checkbox"/> Eye strain	<input type="checkbox"/> Eye inflammation	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Ear noises	<input type="checkbox"/> Ear discharge
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Nose pain	<input type="checkbox"/> Nose bleeding
<input type="checkbox"/> Nose discharge	<input type="checkbox"/> Breathing difficulty	<input type="checkbox"/> Sore gums
<input type="checkbox"/> Sore mouth	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Speech difficulty	<input type="checkbox"/> Dental problems	

Activities of Daily Living

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item

SECTION 3 LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

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 Complaint(s): Place an (X) in the appropriate complaint areas.
Place an (X) in the appropriate complaint areas.

SPINE

- Low back
- Pelvis
- Mid back
- Neck

UPPER EXTREMITY

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

LOWER EXTREMITY

- Hip R/L
- Leg R/L
- Thigh R/L
- Ankle R/L
- Knee 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

0

LOW PAIN

1 2 3

MODERATE PAIN

4 5 6

INTENSE PAIN

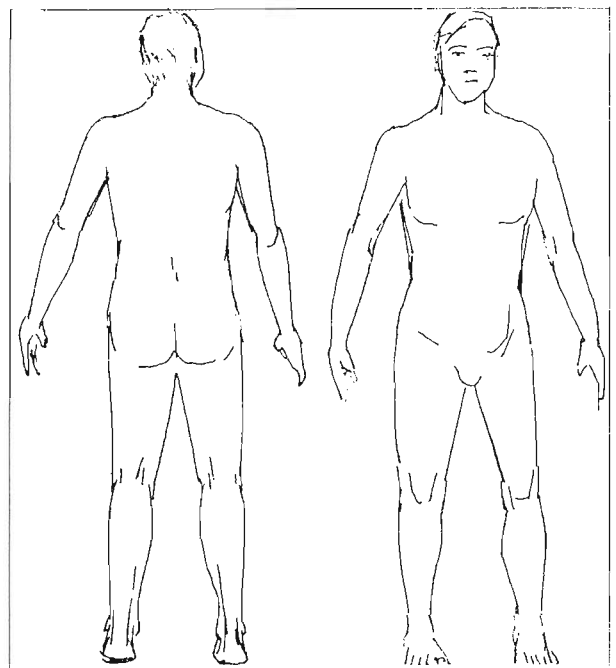
7 8 9

EMERGENCY

10

Mark the areas on 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