AUTO ACCIDENT/PERSONAL INJURY QUESTIONNAIRE

Name_________________________________ DOB___/___/_____ Today's Date___/___/_____

Address_____________________________ City___________________ State____ Zip_______

Phone H________________ W_________________ C________________ SS#_____________

Marital Status S M D W Sep Height __________ Weight___________ Smoker Y N

Alcohol Y N Occupation_________________________ Employer_____________________

Are you experiencing any of the following: (please check)

☐ Neck pain/stiffness ☐ Shoulder pain ☐ Headaches ☐ Upper back pain

☐ Lower back pain ☐ Fatigue ☐ Anxiety ☐ Numbness/weakness of the upper/lower extremities

☐ Dizziness ☐ Difficulty sleeping ☐ Visual disturbances ☐ Nausea/vomiting

☐ Difficulty concentrating ☐ Depression ☐ Other ______________________________

Past Medical History:

____

____

Past Personal Injuries Y N (If YES please give dates and details)

____

____

Past Worker's Comp Injuries Y N (If YES please give dates and details)

____

____

Sports or other injuries to head, neck or back: ____
____
____

Current medical history:

Current health problems: ☐ None
____
____

Current medications taken: ☐ None
____
____

Do you use a heel lift, orthotic, or arch support? _____ Yes _____ No

Females, are you pregnant or think you are? ______ Yes _______ No

Date of first day of last menstrual period: ______________________

I. Injury History (General)

Date and time accident occurred____________________________ Location _______________________________
Who did you report the accident to? ________________________________ Was a police report made? ☐ Y ☐ N
Please explain in detail how this accident occurred (if an auto accident, indicate on the diagram what happened, also indicate north using arrow in circle)

____
____
____
____
____
____
____
____
____
____

(1) You were struck from: ☐ Front ☐ Behind ☐Left side ☐ Right side (2) You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other _________________
(3) Vehicle driven by: __________________ (4) Your vehicle (year, make, model) _________________________
(5) Your estimated speed at moment of accident: _______________ (6) ☐ Stopped ☐ Slowing ☐ Accelerating
(7) Other vehicle (year, make, model) ___________________ (8) Time: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
(9) Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other__________________________________
(10) Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
(11) If adjustable, was position altered by the accident? ☐ Yes ☐ No (12) Was the seat back adjustment altered by the accident? ☐ Yes ☐ No (13) Was the seat broken? ☐ Yes ☐ No (14) Lap belt: ☐ wearing ☐ not wearing ☐ don't know (15) Shoulder belt: ☐ wearing ☐ not wearing ☐ don't know (16) Did air bag deploy? ☐ Yes ☐ No If yes, were you struck? ☐ Yes ☐ No (17) Body position: ☐ Good ☐ Forward lean ☐ Other _________________
(18) Head position: ☐ Forward ☐ Left____ ☐ Right____ ☐ Up____ ☐ Down____ (19) Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A (20) Brakes applied? ☐ Yes ☐ No (21) Aware of impending crash? ☐ Yes ☐ No

II. During the Crash

Did you strike any parts of the vehicle? ☐ Yes ☐ No If YES, describe____________________________________
Did vehicle strike any objects after crash? ☐ Yes ☐ No If YES, describe__________________________________
Wearing hat or glasses? ☐ Yes ☐ No If YES, were they still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No If YES, for how long? ____
Estimated property damage to your vehicle: $____________
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major

III. After the Crash

Please describe you <u>PRESENT COMPLAINTS</u> and <u>SYMPTOMS</u>:____
____
Since the injury, are your symptoms: ☐ Improving ☐ Same ☐ Getting worse
Describe how you felt:
<u>DURING</u> the accident:____
<u>IMMEDIATELY AFTER</u> the accident:____
<u>LATER</u> that day:____
<u>NEXT</u> day:____
Where were you taken after the accident?____
How were you transported from the scene of the accident?_______________________________________
Have you treated with any other doctor(s) since the accident? ☐ Yes ☐ No
If yes, please provide names and dates seen:____
Please describe your job acitivities:____
Have you lost time from work since the accident? ☐ Y ☐ N If YES, first day you were unable to work:___/___/___
Have you returned to work? ☐ Y ☐ N If YES, when? ___/___/____
Are your work activities restricted as a result of the accident? ☐ Y ☐ N If YES, please explain:_______________
____
Have you ever had any complaints in the involved area before? ☐ Y ☐ N If YES, please explain: _____________
____
Do you have any congenital (from birth) factors that relate to this problem? ☐ Y ☐ N If YES, please explain:____
____
Have you been involved in any previous accidents? ☐ Y ☐ N If YES, please describe date and type of injuries sustained:____
____

Have you retained an attorney? ☐ Y ☐ N If YES, please provide name, address and phone number:_________
____

Please give NAME of the Accident Insurance Company, billing address, phone number, claim number, and the contact person's name:____
____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

________________________________ ________________

Patient Signature Date

________________________________ ________________

Doctor's Signature Date