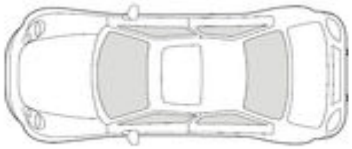
Accident History Questionnaire

Name_____Date_____

1. Date of accident_____
2. Time of accident_____ AM/PM
3. Driver of the car_____
4. Where were you seated?_____
5. Who owns the car?_____
6. Year and model of your car_____
   Year and model of the other car(s)_____
7. What was the approximate damage done to your car? $_____
8. Visibility at time of the 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



11. Type of Accident: ☐ Head-on Collision ☐ Broad-side collision ☐ Front Impact
    ☐ Rear-end car in front ☐ Non-collision
12. At the time of the accident, recall what parts of your head of 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 care 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 head
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:
    ☐ Heat turned right/left ☐ 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? Please list: _____
27. Could you move all parts of your body? ☐ Yes ☐ No
28. If no, what parts of your body 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	☐ 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. Name of Doctor seen : _____
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 treatment? _____
49. Date of last treatment? _____
50. Did you see another doctor? ☐ Yes ☐ No – if no please skip to question 58
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 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:

Patient Signature: _____

Date: _____