

Patient Auto Accident Questionnaire

1. Date accident occurred or started? ___/___/___

2. Time of day when accident occurred or started? _____

3. Describe how accident the accident took place.

4. Were you the Driver Passenger Pedestrian

5. Automobile you were in Year_____ Make_____ Model_____

6. Damage to your car Front Rear Driver Side Passenger Side Bumper Fender

7. Damage amount estimated? \$_____ Minor Major Totaled

8. Other automobile Year_____ Make_____ Model_____

9. Damage to other car Front Rear Driver Side Passenger Side Bumper Fender
 Minor Major Totaled

10. Where did this accident happen? Street _____ City _____ State _____

11. Was it? Controlled Intersection Uncontrolled Not Intersection

12. Was there a traffic light? None Green Red Turn Arrow Stop Sign

13. Were you? Slowly Moving Moving Stopped

14. Weather Conditions? Sunny Rainy Cloudy

15. Street Surface?

- Dry Wet Slick
- Icy Pavement Other _____

16. Type of impact? Rear End Front Side Impact Roll-over

17. Brakes on impact? Locked tight Loosely Applied Foot not on brake



18. How far did the car move?

Did not move

Moved 1-5ft

Moved 6-10ft

Moved over 10 Feet

19. Where were you seated in the vehicle? _____

20. Were you wearing a seat belt? Yes No

21. Shoulder Harness? Yes No

22. Headrest Position? Up Down

23. Is car equipped with air bags? Yes No Did they deploy? Yes No

24. Did you see the impact coming? Yes No Did you brace yourself for impact? Yes No

25. On impact your head was looking?

Ahead

Behind

Up

Down

To the right

To the left

Other _____

26. On impact were you

Thrown forward

Thrown backwards

Thrown sideways

Other _____

27. Did your body hit anything inside the car? Yes No Body Part _____

28. What did you hit? _____

29. Head trauma? Yes No Loss of consciousness? Yes No How long? _____

30. Do you remember the accident happening? Yes No

31. Hospital Yes No Hospital Name _____

How long were you're their? _____ Taken by ambulance? Yes No

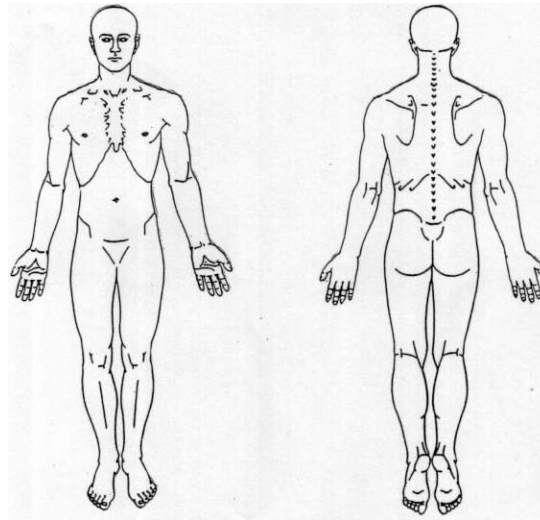
32. X-Rays Taken? Yes No

X-Ray Areas? Neck Mid Back Lower Back Other _____

33. Medication Given? Yes No RX _____

34. Other Instruction _____ Follow up _____





Please mark area(s) of health concern with X.

35. Describe your pain: Burning Pain Sharp pain Dull Pain Ache

A. What caused it? _____

B. What aggravates it? _____

C. What relieves it? _____

36. Please check any of the following symptoms you are now experiencing:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Head seems heavy | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Clumsiness |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> tingling in arms/legs | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Face Flushed |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in hands/arms | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Numbness legs/feet | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Chest pain/Rib pain | <input type="checkbox"/> Pain in arms/legs | <input type="checkbox"/> Pain in legs/feet | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Sharp/Shooting pain | <input type="checkbox"/> Loss of strength Legs | <input type="checkbox"/> Loss of strength – arms | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Difficulty swallowing | | <input type="checkbox"/> Other: _____ | |

37. Have you experienced changes to:

- | | | | |
|---------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Eyes (sight) | <input type="checkbox"/> Earring (hearing) | <input type="checkbox"/> Nose (smell) | <input type="checkbox"/> Mouth (taste) |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Bowels | <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotion |
| <input type="checkbox"/> Appetite | | | |

Please explain:



38. Have you missed work or school as a result of your injuries? Yes No

39. Do you smoke? Yes No Number of Packs/Day? _____

40. Do you drink alcohol? Yes No Number of drinks? _____

41. Have you been in our office before? Yes No

42. List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

Previous accident:	Date:
1.	
2.	
3.	

Surgeries/Hospitalizations	Year

43. Allergies?

44. List all medications you are now taking and why:

Name	Quantity/day	Reason

45. Do you now or have you ever had:

- Heart Disease
- Stroke
- Thyroid Problem
- Stroke
- Other: _____
- Diabetes
- Tuberculosis
- Kidney Problems
- Seizure Disorder
- Cancer
- Asthma
- Ulcer
- Scoliosis
- High Blood Pressure
- Prostate Disorder
- Cardiovascular problems
- Back Problems

