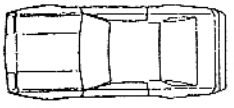
# Accident History Questionnaire

## *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?

FRONT  REAR

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? _____

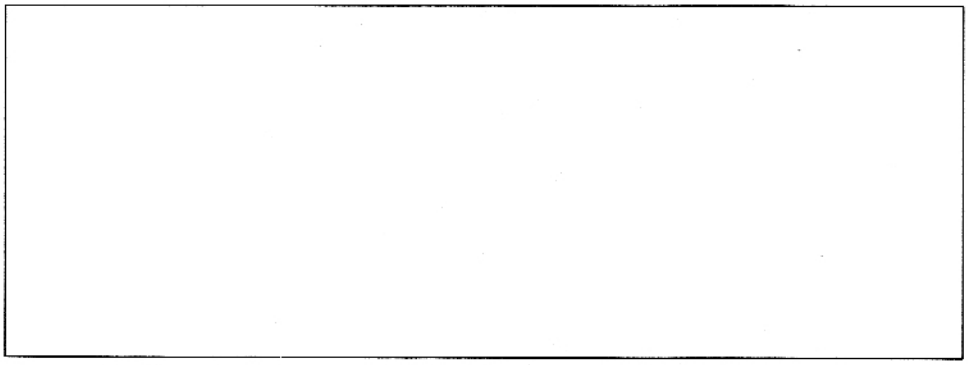
Name: _____

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 _____

 Name: _____

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

### *Genito-Urinary System*

- ☐ Bladder trouble
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Discolored urine
- ☐ Scanty urination

### *Gastro-Intestinal System*

- ☐ Poor appetite
- ☐ Difficult swallowing
- ☐ Vomiting food
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight trouble
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Abdominal pain
- ☐ Black stool
- ☐ Liver trouble
- ☐ Difficult chewing
- ☐ Nausea
- ☐ Diarrhea
- ☐ Bloody stool
- ☐ Gall bladder trouble

### *Nervous System*

- ☐ Numbness
- ☐ Dizziness
- ☐ Muscle jerking
- ☐ Confusion
- ☐ Loss of feeling
- ☐ Fainting
- ☐ Convulsions
- ☐ Depression
- ☐ Paralysis
- ☐ Headaches
- ☐ Forgetfulness

### *Cardio-Vascular System*

- ☐ Chest pain
- ☐ Persistent Cough
- ☐ Rapid heartbeat
- ☐ Lung problems
- ☐ Pain over heart
- ☐ Coughing phlegm
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Difficult breathing
- ☐ Coughing blood
- ☐ Heart problems
- ☐ Other

### *Eye, Ear, Nose and Throat System*

- ☐ Eye strain
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Nose discharge
- ☐ Sore mouth
- ☐ Speech difficulty
- ☐ Eye inflammation
- ☐ Ear noises
- ☐ Nose pain
- ☐ Breathing difficulty
- ☐ Sore throat
- ☐ Dental problems
- ☐ Vision problems
- ☐ Ear discharge
- ☐ Nose bleeding
- ☐ Sore gums
- ☐ Hoarseness

**PRIMARY COMPLAINT:**

When did this condition develop?_____ Did it develop? (Circle one) Immediately/Gradually?

What is the exact location of your symptoms?_____

What do you think caused this condition?_____

How often do you experience these symptoms? (Circle one)

Constant / Frequent (75%) / Often (50%) / Seldom (25%) / Rarely (less than 25%)

What is the type of pain you are experiencing? (Circle all that apply)

Dull Sharp Burning Aching Stabbing Throbbing Numbness Twitching

Rate your symptoms on a scale of 1-10 (circle one) minimal 1 2 3 4 5 6 7 8 9 10 severe

Does the pain travel or radiate to another area of your body? YES___ NO___

If yes, what area? _____

What provokes or aggravates your condition (circle all that apply)?

Sitting / Standing / Walking / Lying/ Pushing / Pulling / Lifting / Hot / Cold / Sneezing / Bowel Movements

What helps alleviate pain (circle all that apply)?

Sitting / Standing / Walking / Lying / Rest / Hot / Cold

Please list any doctors that you have seen for this condition (Include address, phone numbers, fax numbers, diagnosis, treatment received, and any change in your condition since you have received Treatment):_____

_____

List any falls, surgeries, hospitalizations, or accidents since your last visit: _____

Patient name: _____

**SECONDARY COMPLAINT:** (If Applicable)

When did this condition develop?_____ Did it develop? (Circle one) Immediately/Gradually?
What is the exact location of your symptoms?_____
What do you think caused this condition?_____

How often do you experience these symptoms? (Circle one)
Constant / Frequent (75%) / Often (50%) / Seldom (25%) / Rarely (less than 25%)

What is the type of pain you are experiencing? (Circle all that apply)
Dull Sharp Burning Aching Stabbing Throbbing Numbness Twitching

Rate your symptoms on a scale of 1-10 (circle one) minimal 1 2 3 4 5 6 7 8 9 10 severe

Does the pain travel or radiate to another area of your body? YES___ NO___
If yes, what area? _____

What provokes or aggravates your condition (circle all that apply)?
Sitting / Standing / Walking / Lying/ Pushing / Pulling / Lifting / Hot / Cold / Sneezing / Bowel Movements

What helps alleviate pain (circle all that apply)?
Sitting / Standing / Walking / Lying / Rest / Hot / Cold

Please list any doctors that you have seen for this condition (Include address, phone numbers, fax numbers, diagnosis, treatment received, and any change in your condition since you have received Treatment):_____
_____

**Additional Notes:**