

Name: _____

Date: _____

ACCIDENT HISTORY QUESTIONNAIRE

Personal Injury Patient History. (All information you give is confidential)

Date of Accident _____ Time _____

Driver of Car _____ Who owns the car? _____

Year and model of your car _____ Other car _____

Where were you seated? _____ Approximate damage to your car \$ _____

Visibility at the time of the accident: Poor Fair Good Comments: _____

Road conditions at the time of accident: Icy Rainy Wet Clear Dark Other _____

Circle where the car was struck
front back

Type of Accident: Head on collision Broad-side collision Rear-end collision Front Impact

At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car: _____

Did you see the accident coming? Y N Did you brace for impact? Y N

Were seatbelts worn? Y N Does your car have headrests? Y N

If yes, what was the position of those headrests before the accident?

Top of headrest even with bottom of head Top of headrest even with top of head Top of headrest even with neck

Was your car breaking? Y N Was your car moving at the time of the accident? Y N

If moving, how fast would you estimate you were going? _____ MPH The other car? _____ MPH

Head/Body position at the time of impact:

Head turned to the Left Right Head looking back Head straight forward

Body straight in sitting position Body rotated Left Right Other _____

As a result of the accident you were:

Rendered Unconscious In shock Dazed, circumstances vague Other _____

Were you wearing a hat or glasses? Y N

Could you move all parts of your body? Y N

If no, what parts couldn't you move and why? _____

Were you able to get out of the car and walk unaided? Y N

If no, why not? _____

Did you get bleeding cuts? Y N If yes, where? _____

Did you get any bruises? Y N If yes, where? _____

Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

Now: _____

Check symptoms apparent since the accident:

- | | | | |
|-----------------------------------------------|--------------------------------------------------|-------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Eye light sensitivity |
| <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Breath shortness | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing/Buzzing | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Muscle soreness |
| <input type="checkbox"/> Other: _____ | | | |

Occupation _____ Employer _____

Have you missed time from work? Y N if yes from _____ to _____

Did you seek medical help immediately after the accident? Y N

If yes, how did you get there? Ambulance Police Someone else drove Drove own car

Doctor #1: Name: _____ First visit date: _____

Were you examined? Y N Were x-rays taken? Y N

What treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last treatment _____

Doctor #2 Name: _____ First visit date: _____

Were you examined? Y N Were x-rays taken? Y N

What treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last treatment _____

Do you have an attorney on this claim? Y N If yes, who? _____

Address: _____ City _____ State _____ Zip _____

Illustrate how the accident happened: