

# ACCIDENT HISTORY QUESTIONNAIRE

## PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_  
Sex  Male  Female How did you hear about the office? \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ AM/PM

Please Describe the accident in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian

## ACCIDENT SITE

Road/Street Name \_\_\_\_\_  
City/State \_\_\_\_\_  
Driving Conditions:  Dry  Wet  Icy  Other \_\_\_\_\_  
Visibility:  Poor  Fair  Good  Other \_\_\_\_\_  
Was your vehicle moving?  Yes  No  
Speed of you vehicle: \_\_\_\_\_ mph

## YOUR VEHICLE

Make and model of your car: \_\_\_\_\_  
Were you wearing a seatbelt?  Yes  No  
Were shoulder harnesses worn?  Yes  No  
Did the airbag inflate?  Yes  No  
Did your seat have a headrest?  Yes  No  
If yes, what was the position of the headrest?  
 Top of headrest even with **bottom** of head  
 Top of headrest even with **top** of head  
 Top of headrest even with **middle** of neck  
Estimate the amount of damage done to your vehicle: \_\_\_\_\_

## OTHER VEHICLE

Make and model other vehicle \_\_\_\_\_  
Speed of other vehicle \_\_\_\_\_ mph

## IMPACT

Did your car impact another vehicle?  Yes  No  
Did your body strike anything inside the vehicle?  
 No  Yes, explain \_\_\_\_\_  
Type of Impact:  Front  Rear  Left  
 Right  Other \_\_\_\_\_  
Head/Body position at the time of impact:  
 Head straight forward  Body Straight  
 Head up/down  Body Rotated right/left  
 Head turned right/left  Other \_\_\_\_\_  
Did you see the accident coming?  Yes  No  
Did you brace for impact?  Yes  No  
Was your car braking?  Yes  No

## ILLUSTRATION OF THE ACCIDENT



**PATIENT CONDITON**

**Were you unconscious after the accident?**  Yes  No **If yes, for how long?** \_\_\_\_\_

**Could you move all parts of your body?**  Yes  No **If no, which parts couldn't you move and why?** \_\_\_\_\_

**Were you able to get out of the car and walk unaided?**  Yes  No, why not? \_\_\_\_\_

**Did you get any bleeding cuts?**  Yes  No **If yes, where?** \_\_\_\_\_

**Did you get any bruises?**  Yes  No **If yes, where?** \_\_\_\_\_

**Please describe how you felt, 1) immediately after the accident?** \_\_\_\_\_

**2) Later that day?** \_\_\_\_\_

**3) The next day?** \_\_\_\_\_

**TREATMENT**

**Did you go to the hospital immediately after the accident?**  Yes  No

**How did you get there?**  ambulance  police  someone else drove me  drove own car

**When did you go?**  Immediately after the accident  Next day  2 days or more after the accident

**Hospital Name:** \_\_\_\_\_ **Name of Doctor :** \_\_\_\_\_

**Treatment received:** \_\_\_\_\_

**Medications given:** \_\_\_\_\_

**X-rays taken:** \_\_\_\_\_

**Did you seek any additional treatment?**  Yes  No **If yes, who did you see?** \_\_\_\_\_

**Date of visit?** \_\_\_\_\_ **Treatment received:** \_\_\_\_\_

**SYMPTOMS**

**Have you missed any days at work since the accident?**  Yes  No **If yes, how many?** \_\_\_\_\_

**If you have had any of the following symptoms since the accident, please check off:**

- Arm/Shoulder pain
- Foot/toe numbness
- Dizziness
- Low back pain
- Neck stiffness
- Ear ringing
- Neck pain
- Headaches
- Memory Loss
- Upper back pain
- Irritability
- Jaw problems
- Chest pain
- Nausea
- Sleep difficulty
- Leg pain
- Stomach upset
- Blurred vision
- Hand/finger numbness
- Chest pain
- Shortness of breath

**Past health history: Place an x if it applies and describe:**

- None related to current complaints
- Hospitalized
- Surgery
- Other auto accident(s)
- Work Accident
- Illness

**Describe condition and treatment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_