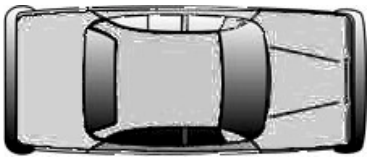
ACCIDENT HISTORY QUESTIONAIRE

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 and Model of your car _____
   Year and Model of other car(s)_____
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?

REAR  FRONT

11. Type of accident: □ Head-on collision □ Broad-side collision □ Front impact
    □ Rear-end in front
12. At the time of the accident, 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 left/right
    □ Head straight forward □ Other: _____
24. As a result of the accident, were you:
    □ 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? _____

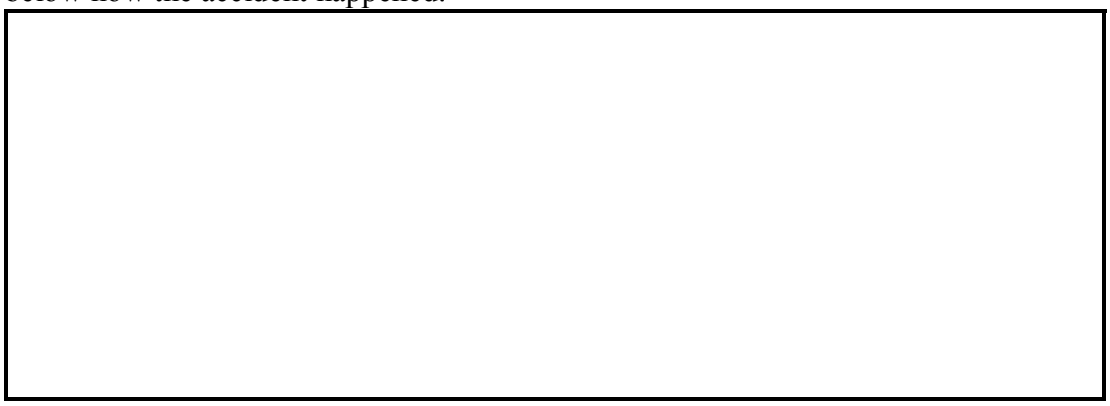
29. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
30. If no, why not? _____
31. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where?_____
32. Did you get any bruises? ☐ Yes ☐ No If yes, where?_____
33. Please describe how you felt:
    Immediately after the accident: _____
    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– fingers
☐ Numbness – 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	☐ Low Back Pain/Stiffness	

    ☐ 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 ☐ Collar
    ☐ Other _____
47. If yes, what kind of treatment? _____
48. What benefits did you receive from the treatment? _____
49. Date of last treatment: _____
50. Were you released from care? ☐ Yes ☐ No
51. Doctor #2: Name: _____
52. First visit date: _____
53. Were you examined? ☐ Yes ☐ No
54. Were x-rays taken? ☐ Yes ☐ No
55. Did you receive treatment? ☐ Yes ☐ No
    ☐ Medications ☐ Braces ☐ Collar
56. If yes, what kind of treatment? _____
57. What benefits did you receive from the treatment? _____
58. Date of last treatment: _____
59. Were you released from care? ☐ Yes ☐ No
60. Do you have an attorney on this claim? ☐ Yes ☐ No

61. If yes, who? _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

Illustrate below how the accident happened:



Past Medical History: Place an (X) if applicable 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 applicable, 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/Illness, describe:_____
_____

Other, describe: _____
_____

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

Genito-Urinary System

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

Gastro-Intestinal System

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

Nervous System

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

Cardio-Vascular System

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

Eye, Ear, Nose, and Throat

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

Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section that most closely applies to you.

SECTION 1 Pain Intensity

- ☐ I can tolerate the pain I have without using painkillers.
- ☐ The pain is bad but I manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers give no relief from pain and I do not use them.

SECTION 2 Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not dressed, wash with difficulty, and stay in bed.

SECTION 3 Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights of they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

SECTION 4 Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can only walk using a cane or crutch.
- I am in bed most of the time and have to crawl to the toilet.

SECTION 5 Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than one hour.
- Pain prevents me from sitting for more than 30 minutes.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6 Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it causes extra pain.
- Pain prevents me from standing more than one hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7 Sleeping

- Pain does not prevent me from sleeping well.
- I can only sleep well using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

SECTION 8 Social Life

- My social life is normal and causes no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 9 Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary trips under ½ hour.
- Pain restricts me from traveling except to the doctor or hospital.

SECTION 10 Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates overall but is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

CURRENT CHIEF COMPLAINT(s)

Place an (X) in the appropriate complaint areas.

SPINE

☐ Low Back ☐ Mid Back ☐ Neck ☐ Pelvis

UPPER EXTREMITY

☐ Shoulder R/L ☐ Arm R/L ☐ Elbow R/L
☐ Wrist R/L ☐ Forearm R/L ☐ Hand R/L

LOWER EXTREMITY

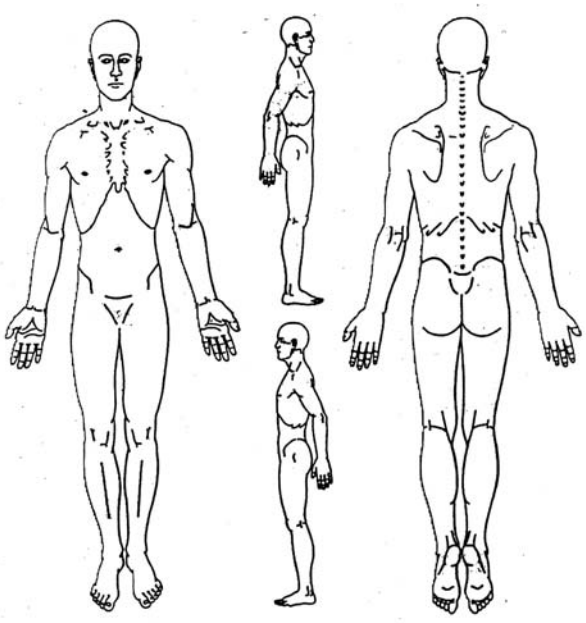
☐ Hip R/L ☐ Thigh R/L ☐ Knee R/L
☐ Leg R/L ☐ Ankle R/L ☐ Foot R/L

OTHER (describe): _____
_____
_____

Subjective Pain Level

On a scale of 1 – 10, place an (X) in your current pain level.

NORMAL
☐ 0
LOW PAIN
☐ 1 ☐ 2 ☐ 3
MODERATE PAIN
☐ 4 ☐ 5 ☐ 6
INTENSE PAIN
☐ 7 ☐ 8 ☐ 9
EMERGENCY
☐ 10



Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.