Automobile Accident Questionnaire

Accident Information

Date: _____

Patient's Name: _____ **DOB:** _____

Address_____**City**_____**State**___**Zipcode**_____

Sex: Male___ Female___

Marital Status: Minor___ Single___ Married___ Separated___ Divorced___ Widowed___ Life Partner of ____years

Home Telephone_____ **Cell Telephone**_____

Occupation _____**Employer** _____

Who may we thank for you referring you? _____

Family/Primary Care Physician_____**Telephone**_____

Auto Insurance *of the vehicle you were in at the time of the accident* _____

Address: _____

Claim Number: _____ Adjuster Name & Telephone: _____

If the insured is different than the patient please provide

Insured's Name: _____ DOB: _____

Address_____City_____State____Zipcode_____

Sex _____ Telephone: _____

Attorney Name: _____**Telephone:**_____

Address: _____

Patient's Primary Health Insurance _____

Subscriber's Name_____ Subscriber's DOB: _____

Policy/ ID# _____ Phone_____

Address: _____

Patient's Secondary Health Insurance _____

Subscriber's Name_____ Subscriber's DOB: _____

Policy/ ID# _____ Phone_____

Address: _____

Patient's Name: _____

Accident Information:

Date of Accident: _____ Time: _____ a.m. /p.m.

Driver of Car: _____ Number of persons in the vehicle: _____
Where were you seated? _____ Did the police arrive? Yes___ No___
Were EMT's at the scene? Yes___ No___ Was an accident report completed? Yes___ No___
State accident occurred in: Delaware___ Other (name) _____

Year and Model of Car: _____
Type of Car: Compact___ Mid-Size___ Full Size___ Compact Truck: ___ Full Truck___ Minivan___ Full Size Van___
Small SUV___ Large SUV___ Motorcycle___ Motor Home___ Bicycle___ Other_____

Other Vehicle: Compact___ Mid-Size___ Full Size___ Compact Truck___ Full Truck___ Minivan___ Full Size Van___
Small SUV___ Large SUV___ Motorcycle___ Motor Home___ Bicycle___ Other_____

Visibility at time of accident: Poor___ Fair___ Good___ Clear___ Other_____

Conditions at time of accident: Icy___ Rainy___ Foggy___ Wet___ Clear___ Dark___ Snowing___
Other:_____

What was your vehicle doing just prior to the accident?
Stopped at a red light ___ At a complete stop__ Slowing down to stop ___ Increasing speed ___ Changing lanes___
Merging into traffic___ Traveling at a constant speed___ Backing up ___

Traveling at an approximate speed of:
Stopped ___ Speed Unknown ___ Moving very slowly (less than 15 mph) ___ Moving slowly (up to 25 mph) ___
Moving at a moderate speed (up to 40 mph) ___ Moving at an increased speed (up to 65 mph) ___
Moving at an excessive speed (> 65 mph) ___

Who hit who?
You were struck by another vehicle ____ You struck another vehicle ____ You struck a stationary object____
You were struck by another vehicle and forced into another vehicle____ other:_____

What was your vehicle's point of impact?
Front___ Rear___ Right Side___ Left Side___ Right Front___ Left Front___ Right Rear___ Left Rear___

Type of accident:
Head on collision___ Broad side collision___ Rear end Collision___ Front impact, rear ended car in front___
Other:_____

What was other vehicle doing just prior to the accident?
Not Sure____ Stopped at a red light ____ At a complete stop____ Slowing down to stop ____ Increasing speed ____
Changing lanes____ Merging into traffic____ Traveling at a constant speed____ Backing up ____

Traveling at an approximate speed of:
Speed Unknown ___ Stopped ___ Moving very slowly (less than 15 mph) ___ Moving slowly (up to 25 mph) ___
Moving at a moderate speed (up to 40 mph) ___ Moving at an increased speed (up to 65 mph) ___
Moving at an excessive speed (> 65 mph) ___

What was their vehicle's point of impact?
Front___ Rear___ Right Side___ Left Side___ Right Front___ Left Front___ Right Rear___ Left Rear___

Were you wearing seat restraints?
Full lap and shoulder restraint___ Lap restraint only___ Shoulder restraint only___ I was not wearing a restraint___

Patient's Name: _____

What position was your vehicle's headrest in?
Lowest position___ Middle position___Highest position___ No headrest in vehicle___ Not Sure___

Did your vehicle's air bags deploy? Yes___ No___ **Did your seat break?** Yes___ No___

Were you prepared for the impact?
Came as a complete surprise___ Aware and braced for impact___ Aware but not braced for impact___ Not sure___

What position was your head and neck at the time of the accident?
Straight forward___ Looking down___ Head turned right___ Head turned left___ Turned around___ Toward rear view mirror___
Other: _____

What happened to your body at the moment of impact?
Body was tensed for impact___ Body whipped forward/backward___ Body torqued and twisted___ Body was thrown over seat___ Body was thrown from vehicle___ Body was pinned in vehicle___ Body was thrown from side to side___
Body was cut and bruised___ Other: _____

What was the position of your arms at the time of impact? _____

Did any part of your head or body strike any part of the vehicle? Yes___ No___
If yes, describe:_____

What was your mental/emotional state immediately following the accident?
Unconscious___ Disoriented___ Shaken up___ Shaken up & Disoriented___ Dazed___ Dizzy___ Other:_____

Were any personal items or clothing such as glasses, hat, etc. thrown about the vehicle?
Yes__ No__ Not Sure__ If yes, describe: _____

Did you have any cuts or bruises from the accident? Yes__ No__
If yes, describe: _____

Did you feel any pain immediately after the accident? Yes__ No__
If yes, describe: _____

How did you feel later that day/night? _____

How did you feel the next day(s)? _____

How much property damage to your vehicle?
Minor___ Moderate___ Extensive___ Totaled___
Vehicle was towed from scene ___

Did you receive medical attention at the scene of the accident? Yes__ No__

Where did you go immediately following the accident?
Taken to hospital by ambulance___ Driven to hospital___ Drove to hospital___ Home___ Medical doctor___ Resumed daily activities___ Other: _____

If you went to the hospital, when did you go?
Same day____ Next day____ Several days later___ 1 Week later___ Several weeks later___ Other_____

Patient's Name: _____

What was done at the hospital?
X-rays: Yes__ No__ If yes, of what body part(s)?_____

CT Scan: Yes__ No__ If yes, of what body part(s)? _____

MRI: Yes__ No__ If yes, of what body part(s)? _____

Were you prescribed medication? Yes__ No__ If yes, describe:_____

Were you admitted? Yes__ No__ If yes, describe: _____

What recommendations made? Yes___ No___
If yes, what follow up was recommended: Primary care doctor___ Physical therapy___ Orthopedic surgeon___ No work___
Other: _____

Other doctor/hospital /clinic seen: _____ Date: _____
Describe treatment/recommendations/prescriptions: _____
_____

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Describe treatment/recommendations/prescriptions: _____
_____

Other doctor/hospital /clinic seen: _____ Date: _____
Describe treatment/recommendations/prescriptions: _____
_____

Occupation: _____

Have you missed time from work? Yes___ No___ If yes, how much time have you missed? _____

Have you returned to work yet? Yes___ No___ If yes, any work restrictions?_____

Have you ever had the same or similar condition or symptoms prior to this accident? Yes___ No___
If yes, describe:_____
_____

Please describe any prior trauma or accidents and any residuals:
_____
_____
_____
_____

Health History

Patient's Name_____

Please check any of the following that you have or have had:

___AIDS/HIV	___Glaucoma	___Pacemaker	___Alcoholism	___Goiter	___Parkinson's Disease
___Allergy Shots	___Gonorrhea	___Pinched Nerve	___Anemia	___Gout	___Pneumonia
___Anorexia	___Heart Disease	___Polio	___Appendicitis	___Hepatitis	___Prostate Problem
___Arthritis	___Hernia	___Prosthesis	___Asthma	___Herniated Disk	___Psychiatric Care
___Bleeding Disorders	___Herpes	___Rheumatoid Arthritis	___Breast Lump	___High Blood Pressure	___Rheumatic Fever
___Bronchitis	___High Cholesterol	___Scarlet Fever	___Bulimia	___Kidney Disease	___STD
___Cancer	___Liver Disease	___Stroke	___Cataracts	___Measles	___Suicide Attempt
___Chemical Dependency	___Migraines	___Thyroid Problems	___Chicken Pox	___Miscarriage	___Tonsillitis
___Diabetes	___Mononucleosis	___Tuberculosis	___Emphysema	___Multiple Sclerosis	___Tumors, Growths
___Epilepsy	___Mumps	___Typhoid Fever	___Fractures	___Osteoporosis	___Ulcers
___Whooping Cough	___Vaginal Infections	___Lupus	___Fibromyalgia		

Other: _____

Are you pregnant? ___ Yes ___ No ___ Not Sure Due Date_____

Exercise:
___None ___Occasionally ___ Daily ___ Heavy

Work Activity:
___Sitting ___ Standing ___Light Labor ___Heavy Labor

Habits:
___ Smoking Packs/Day_____ ___Alcohol Drinks/Week_____ ___Coffee/caffeine drinks Cups/Day_____
___High Stress Level Reason_____

Previous injuries:
Please include description and dates
Falls_____
Head Injuries_____
Broken Bones_____
Dislocations_____
Surgeries_____

Medications:
_____
_____
_____
_____
_____

Family History:

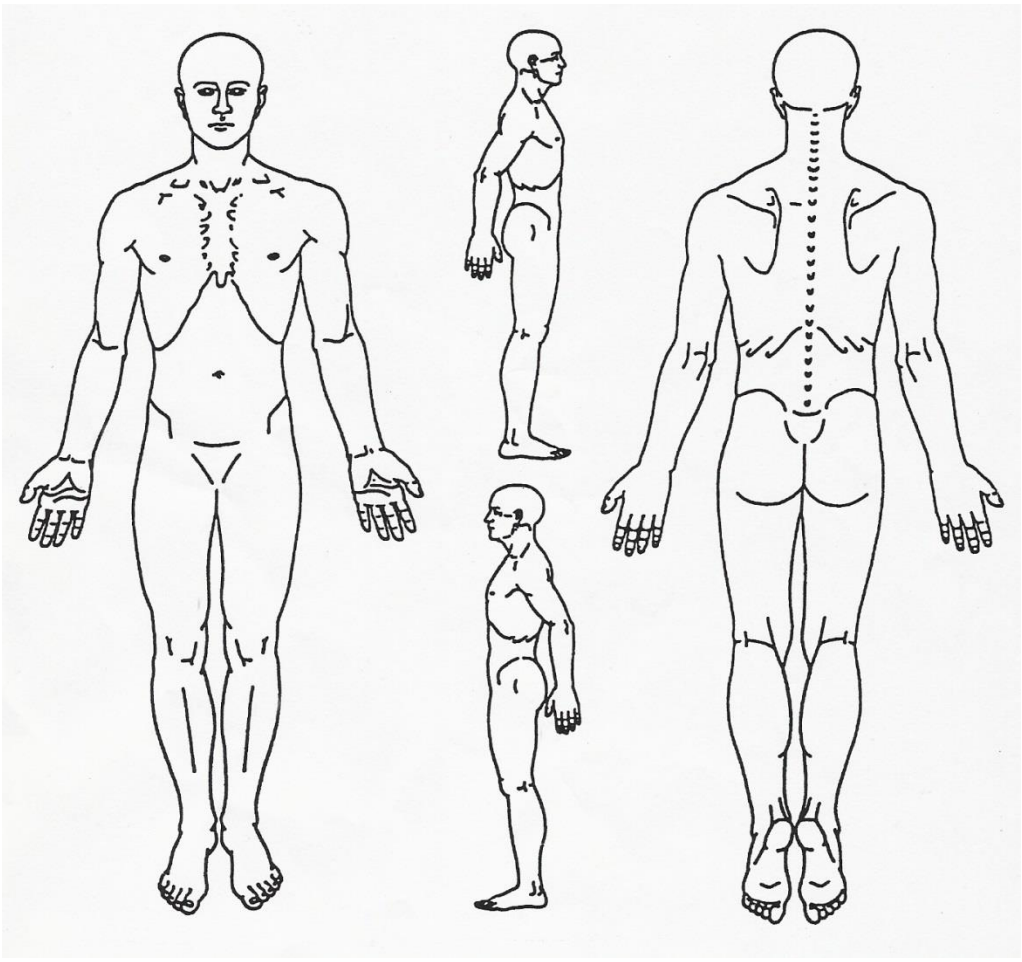
Please describe any relevant, immediate family history, e.g. cancer, diabetes, heart disease, etc.
_____
_____
_____
_____
_____

Patient's Name:_____ DATE:_____

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

How long have you experienced neck/back pain? _____

Is this your first episode of neck/back pain? _____ YES _____ NO

How often do you have this pain? _____

What makes the pain worse? _____

What decreases the pain? _____

Activities of Daily Living

Patient Name_____ **Date**_____

Mark all of the below functions that you are unable to perform or are having difficulty performing due to each of the conditions indicated above.

Personal Care:
Eating __ Dressing __ Grooming/Hygiene __ Bathing __ Eliminating __
Additional Info:
_____

Communication:
Hearing __ Speaking __ Reading __ Writing __ Using a keyboard __
Additional Info:
_____

Activity:
Sleeping __ Standing __ Walking __ Sitting __ Running __ Working __ Heavy lifting __ Medium lifting __
Light lifting __ Lifting weights __ Having sex __ During sports __ Working around the house __
Working on hobbies __ Exercising __
Additional Info:
_____

Sensory:
Hearing __ Seeing __ Feeling __ Tasting __ Smelling __
Additional Info:
_____

Recreation/Travel:
Driving a car __ Riding in a car __ Riding in a boat __ Traveling in an airplane __ Traveling in a train __ Riding a bike__
Additional Info:
_____

Social Activities:
Participating in group activities __ Speaking in public __ Emotional Stability __
Additional Info:
_____

Other:_____
_____
_____
_____
_____
_____