Auto Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of accident: _____ Time: _____
2. Driver of car: _____
3. Where were you seated? _____
4. Who owns the car? _____
5. Year, make and model of car: _____
6. What was the approximate damage done to your car? _____
   _____
7. Visibility at the time of the accident was: ☐Poor ☐Fair ☐Good ☐Other ____
8. Road conditions at the time of accident: ☐Icy ☐Icy ☐Wet ☐Clear ☐Dark ☐Other, describe,: _____
9. Where was you car struck: ☐Right ☐Left ☐Rear ☐Front ☐Side
10. Type of accident: ☐Head on Collision ☐Broad-side collision ☐Front impact ☐Rear-ended by another vehicle ☐Rear end car in front ☐Non collision
11. Describe in you own words what happened to you upon impact:
    _____
    _____
    _____
12. Did you see it coming? ☐Yes ☐No
13. Did you brace on impact? ☐Yes ☐No
14. Did you have your seatbelt on? ☐Yes ☐No
15. Were shoulder harnesses worn? ☐Yes ☐No
16. Does your car have headrests? ☐Yes ☐No
17. If yes to 16 then 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
18. Was your car braking? ☐Yes ☐No
19. Was your car moving at the time of the accident? ☐Yes ☐No
20. If yes, how fast would you estimate you were going? _____MPH
21. How fast would you estimate the other car was going? _____MPH
22. Head \ body position at the time of impact:
    ☐Head turned ☐left ☐right.
    ☐Head looking back.
    ☐Head straight forward.
    ☐Body straight in sitting position.
    ☐Body rotated ☐right ☐left
    ☐Other: _____
23. At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car: _____
24. As a result of ;the accident you were: ☐rendered unconscious ☐Dazed, circumstances vague ☐Other: _____
25. Could you move all parts of you body? ☐Yes ☐No

26. If no to 25 what parts couldn't you move and why? _____

_____

27. Were you able to get out of the car and walk unaided? ☐Yes ☐No
28. If no, why not? _____
29. Did you get bleeding cuts? ☐Yes ☐No
30. If yes, where are they located and how long, in inches? _____

_____

31. Did you get bruises? ☐Yes ☐No
32. If yes, where are they located and how long, in inches? _____

_____

33. Please describe how you felt:
    - ☐Immediately after the accident: _____
    - ☐Later that day: _____
    - ☐The next day: _____
34. Check the symptoms apparent since the accident?

☐Headache	☐Neck pain	☐Mid back pain	☐Eye's sensitive to light
☐Dizziness	☐Fainting	☐Sleeping problems	☐Pain behind the ;eyes
☐Loss of smell	☐Fatigue	☐Loss of taste	☐Numbness in fingers
☐Irritability	☐Depression	☐Loss of memory	☐Numbness in toes
☐Rigging in ears	☐Tension	☐Short of breath	☐Loss of balance
☐Cold hands	☐Cold feet	☐Diarrhea	☐Constipation
☐Chest pain	☐Nervousness	☐Cold sweats	☐Anxious

☐Other: _____

35. Occupation: _____
36. Employer: _____
37. Have you missed time from work? ☐Yes ☐No
38. If yes to 37 full time off work _____ to _____
39. If yes to 37 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 drove me ☐Drove own car ☐Other: _____
42. Doctor # 1 Name: _____
43. Date of visit (s) _____ to _____
44. Were you examined? ☐Yes ☐No
45. Were X-rays taken? ☐Yes ☐No
46. Did you receive treatment? ☐Yes ☐No What: _____
47. Did you benefit from the treatment? ☐Yes ☐No
48. Date of last treatment? _____
49. Doctor # 2 Name: _____
50. Date of visit (s) _____ to _____
51. Were you examined? ☐Yes ☐No
52. Were X-rays taken? ☐Yes ☐No
53. Did you receive treatment? ☐Yes ☐No What: _____
54. Did you benefit from the treatment? ☐Yes ☐No
55. Date of last treatment? _____

56. Doctor # 3 Name: _____
57. Date of visit (s) _____ to _____
58. Were you examined? ☐Yes ☐No
59. Were X-rays taken? ☐Yes ☐No
60. Did you receive treatment? ☐Yes ☐No What: _____
61. Did you benefit from the treatment? ☐Yes ☐No
62. Date of last treatment? _____
63. Do you have an attorney on this claim? ☐Yes ☐No
64. If yes, who? _____
Address: _____
City: _____ State: _____ Zip _____ Phone _____

Signature _____ Date: _____