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VEHICLE ACCIDENT QUESTIONNAIRE

PATIENT INFORMATION

Date:_____

Patient Name: _____ DOB:_____

Address:_____ZIP_____ Phone:_____

Marital Status: Single / Married / Divorced / Widowed Sex: Female / Male

Attorney Name:_____ Phone:_____

ACCIDENT INFORMATION

Date of Accident:_____ Time:_____ AM / PM

Accident Location: _____ City/State:_____

Driving Conditions: Dry / Wet / Icy Other:_____ Speed you were traveling:_____

Year/Make/Model of vehicle YOU were in:_____

Were you the: Driver / Front Passenger / Rear Passenger / Pedestrian

How many people in YOUR vehicle? ____

Were YOU wearing a Seatbelt: Yes / No If yes, what type: Lap / Shoulder

Was YOUR vehicle equipped with Airbags? Yes / No Did they inflate? Yes / No

Did YOUR seat have a Headrest? Yes / No Position of the headrest: Low / Mid Position / High

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Year/Make/Model of OTHER vehicle: _____ Speed of the OTHER vehicle:_____

Direction the OTHER vehicle heading: _____

Was impact from: Front / Rear / Left / Right Other: _____

At the time of impact were you:
Looking Straight Ahead / Looking Up / Looking Down / Looking to the Left / Looking to the Right

Were both hands on the steering wheel? Yes / No If no, which hand was on steering wheel? Right / Left

Was your foot on the brake? Yes / No Were you surprised by Impact? Yes / No

Did you brace for Impact? Yes / No Did police come to the accident site? Yes / No

Was a police report filed? Yes / No Was a traffic violation issued? Yes / No To whom? _____

Describe Accident in your own words (Include direction that you were headed):

_____

_____

Did any part of YOUR body strike anything in the vehicle? Yes / No
If, yes please explain:_____

Were you unconscious immediately after the accident? Yes / No If yes, how long? _____

Please describe how you felt **immediately** after the accident: _____

_____

Did you go to the hospital? Yes / No When? Immediately after the accident / Next Day

How did you get to the hospital? Ambulance / Private Transportation

Name of Hospital: _____ X-rays taken? Yes / NO

Treatment Received:_____

Have you been able to work since the accident? Yes / No
If NO, how many days or hours have you have missed: _____

Prior to injury, were you able to work without restrictions? Yes / No

If you mark "X" on any of the following symptoms you've had since the accident

__Arm/Shoulder pain	__Feet/Toe numbness	__Neck pain	__Dizziness	__Ear buzzing
__Back pain	__Hand/Finger numbness	__Neck Stiffness	__Fatigue	__Ear ringing
__Back stiffness	__Headaches	__Jaw problems	__Irritability	__Sleep difficulty
__Chest pain	__Memory loss	__Leg pain	__Nausea	__Stomach upset
__Shortness of Breath	__Tension	__Vision blurred	__Other_____	

Is the condition getting progressively worse? Yes / No / Same

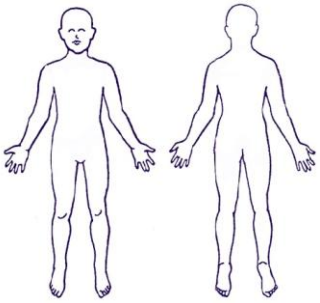
Severity of pain on a scare from 1 (least pain) to 10 (severe pain) AND what area:

_____ _____

_____ _____

Mark with "X" the type of pain then write area & how often (constant "**C**", frequently "**F**", Occasionally "**O**")

__Sharp_____	__Dull_____
__Throbbing_____	__Aching_____
__Burning_____	__Shooting_____
__Cramps_____	__Swelling_____
__Tingling_____	__Stiffness_____
__Numbness_____	__Other_____



Mark an "X" on the diagram above where you have pain, numbness, or tingling

Do your symptoms interfere with your: Work / Sleep / Daily Routine / Recreation Activities

What movements increase pain: Sitting / Standing / Walking / Bending / Lying Down

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To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change of health condition.

_____ _____

Signature of Patient or Patient Guardian/Representative Date

_____ _____

Print Name of Person Signing Above Relationship to Patient, if not Self