

# Accident History Questionnaire

## 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 & Model of your car. \_\_\_\_\_  
Year & Model of other car. \_\_\_\_\_
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?

FRONT



BACK

In your own words, please describe accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Type of Accident:  Head-on collision  Broad-side collision  Front Impact  Rear-end car in front  Rear impact  Non-collision
12. At the time of the accident, recall 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 right/left  Head straight forward  Other: \_\_\_\_\_
24. As a result of the accident you were:  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:
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Headache             | <input type="checkbox"/> Neck pain/Stiffness | <input type="checkbox"/> Mid back pain           |
| <input type="checkbox"/> Eyes Light Sensitive | <input type="checkbox"/> Pain Behind Eyes    | <input type="checkbox"/> Dizziness               |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Sleeping problems   | <input type="checkbox"/> Numbness in fingers     |
| <input type="checkbox"/> Numbness in toes     | <input type="checkbox"/> Loss of smell       | <input type="checkbox"/> Loss of taste           |
| <input type="checkbox"/> Loss of memory       | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Breath shortness        |
| <input type="checkbox"/> Irritability         | <input type="checkbox"/> Depression          | <input type="checkbox"/> Ringing/Buzzing         |
| <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Tension             | <input type="checkbox"/> Cold Hands              |
| <input type="checkbox"/> Cold feet            | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Constipation            |
| <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Cold Sweats             |
| <input type="checkbox"/> Anxious              | <input type="checkbox"/> Facial Pain         | <input type="checkbox"/> Clicking or Popping Jaw |
| <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> 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 Collars
47. If yes, what kind of treatment did you receive? \_\_\_\_\_
48. What benefits did you receive from the treatment? \_\_\_\_\_
49. Date of last treatment? \_\_\_\_\_
50. Doctor #2: Name: \_\_\_\_\_
51. First Visit Date: \_\_\_\_\_
52. Were you examined? yes no
53. Were X-rays taken? yes no
54. Did you receive treatment? yes no Medications Braces Collars
55. If yes, what kind of treatment did you receive? \_\_\_\_\_
56. What benefits did you receive from the treatment? \_\_\_\_\_
57. Date of last treatment: \_\_\_\_\_

58. Do you have an attorney on this claim? yes no

59. If yes, who? \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Illustrate below how the accident happened

Past Medical History: Place an (X) if it applies 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    Cancer    Hypertension    Migraines  
Heart Attack    Other, list: \_\_\_\_\_

Personal History: Place an (X) if it applies, 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, describe \_\_\_\_\_  
\_\_\_\_\_

Other, describe \_\_\_\_\_  
\_\_\_\_\_

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

### ***Genito-Urinary System***

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bladder trouble   | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Scanty urination |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Disclosed urine     |   |

### ***Gastro-Intestinal System***

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Poor appetite        | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Difficult chewing    |
| <input type="checkbox"/> Difficult swallowing | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Nausea               |
| <input type="checkbox"/> Vomiting food        | <input type="checkbox"/> Abdominal pain   | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Constipation         | <input type="checkbox"/> Black stool      | <input type="checkbox"/> Bloody stool         |
| <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Liver trouble    | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Weight trouble       |   |   |

### ***Nervous System***

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Numbness       | <input type="checkbox"/> Loss of feeling | <input type="checkbox"/> Paralysis     |
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Headaches     |
| <input type="checkbox"/> Muscle jerking | <input type="checkbox"/> Convulsions     | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Confusion      | <input type="checkbox"/> Depression      |  |

### ***Cardio-Vascular System***

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Chest pain       | <input type="checkbox"/> Pain over heart     | <input type="checkbox"/> Difficult breathing |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Coughing phlegm     | <input type="checkbox"/> Coughing blood      |
| <input type="checkbox"/> Rapid heartbeat  | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart problems      |
| <input type="checkbox"/> Lung problems    | <input type="checkbox"/> Varicose veins      | <input type="checkbox"/> Other               |

### ***Eye, Ear, Nose and Throat System***

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Eye strain        | <input type="checkbox"/> Eye inflammation    | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear pain          | <input type="checkbox"/> Ear noises          | <input type="checkbox"/> Ear discharge   |
| <input type="checkbox"/> Hearing loss      | <input type="checkbox"/> Nose pain           | <input type="checkbox"/> Nose bleeding   |
| <input type="checkbox"/> Nose discharge    | <input type="checkbox"/> Breating difficulty | <input type="checkbox"/> Sore gums       |
| <input type="checkbox"/> Sore mouth        | <input type="checkbox"/> Sore throat         | <input type="checkbox"/> Hoarseness      |
| <input type="checkbox"/> Speech difficulty | <input type="checkbox"/> 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 which most closely applies to you.

### ***SECTION 1 PAIN INTENSITY***

- I can tolerate the pain I have without using pain killers.
- The pain is bad but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers 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 the most aspects of self care.
- I do not get 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 if 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 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk using a cane or crutches.
- 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 for more than one hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### **SECTION 7 SLEEPING**

- Pain does not prevent me from sleeping well.
- I can sleep well only by 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 SEX LIFE**

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

### SECTION 9 SOCIAL LIFE

- My social life is normal and gives me 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 (dancing, etc.)
- 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 10 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 the journeys of less than one hour.
- Pain restricts me to short necessary trips[s under a 1/2 hour.
- Pain restricts me from traveling except to the doctor or hospital.

### 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

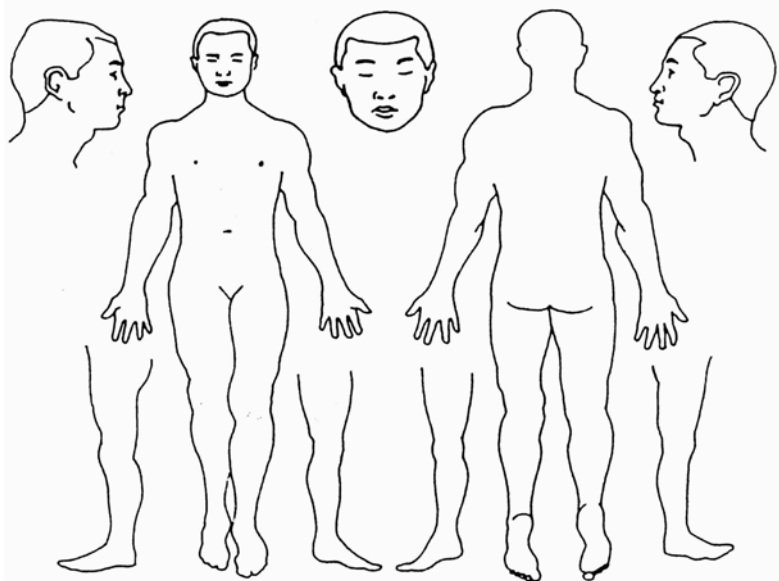
INTENSE PAIN

7     8     9

EMERGENCY

10

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



X NUMBNESS + BURNING

O PIN & NEEDLES = STABBING

\_\_\_\_\_  
Patient's Signature