

Patient Questionnaire – Auto-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient Yes No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Auto-Accident Specific Information:

Were you the: Driver Passenger Pedestrian Bicyclist

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Damage Amount Estimate: \$ _____ : Minor Major Totaled Moderate Unsure

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Minor Major Totaled Moderate Unsure

Where did the accident happen? Street Names: _____ City/State _____

Was it? Controlled Intersection Uncontrolled Not Intersection

Was there a traffic light? None Green Red Turn Arrow Stop Sign

Were you: Slowly Moving Moving Stopped

Weather Conditions: Sunny Rainy Cloudy

Street Surface: Dry Wet Slick Icy Pavement Other _____

Type of Impact: Rear end Front Side Impact Roll Over

Brakes on Impact: Locked Tight Loosely Applied Foot not on brake

How far did your car move? Did not move Moved 1-5 ft Moved 6-10 ft Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? Yes No

Shoulder harness: Yes No Headrest: Yes No Headrest Position: Up Down

Is the car equipped with airbags? Yes No Did they deploy? Yes No

Did you see the impact coming? Yes No Did you brace yourself for impact? Yes No

On impact, your head was looking: Ahead Behind Up Down To the Right To the Left

On impact were you: Thrown forward Thrown backwards Thrown sideways Other _____

Did your body hit anything inside the car? Yes No Body Part: _____

What did it hit? _____

Head trauma? Yes No Loss of Consciousness? Yes No For how long? _____

Do you remember the accident happening? Yes No

Hospital? Yes No Name of hospital: _____ How long there? _____

Taken by ambulance? Yes No

X-rays taken? Yes No X-ray areas: Neck Mid-back Low-back Other X-rays _____

Medication Given? Yes No RX: _____

Other instruction: _____ Follow-up: _____

Additional Information Related to the Condition:

Describe your pain: Sharp Dull Stabbing Aching Radiating Burning Throbbing Numbness

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No

When? ___/___/___

Describe: _____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Notes: _____

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

- 1) _____ ___/___/___
- 2) _____ ___/___/___
- 3) _____ ___/___/___

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

List all medications you are now taking and why: _____