ACCIDENT HISTORY
Questionnaire

PERSONAL INJURY PATIENT HISTORY

I. CLIENT PERSONAL INFORMATION

Name:______________________________ Date:____________

Address:____

City/State/Zip:__________________________ SS#:____________

Telephone: Home____________ Work____________ Message____________

Age:_____ Birthdate:__________ Place of Birth:____________________

Education:____

Highest grade:________ Degrees:____________________

II. THE ACCIDENT

1. Date of Accident:____________________ 2. Time of Accident ________ a.m./p.m.

3. Location of Accident:______________________________________

3a. Was the accident investigated? _____ If yes, name of law enforcement agency who investigated the accident:__________________________ Accident Report # __________

4. Driver of Car ______________________________________

5. Address of Driver: __________________________________

6. Insurance Name & Address:____________________________

7. Other Driver's Name: ________________________________

8. Other Driver's Address:______________________________

9. Other Driver's Insurance:____________________ Policy/Claim #__________

10. Address:____

11. Adjuster's Name & Address:____________________________

12. Witness(es):____

13. Address:____

14. What witness will testify to?_____________________________

15. Where were you seated?___________________________________

16. Who owns the car?_______________________________________

17. Year & Model of car:_____________________________________

18. What was the approximate damage done to your car? ______________

____

19. Visibility at time of accident: ____Poor ____Fair ____Good ____Other:____________

20. Road conditions at time of accident: ____Icy ____Rainy ____Wet ____Clear____Dark

____Other (Describe):____________________________________

21. Where was your car struck?____Right ____Left ____Rear ____Front ____Side

____Other (Describe):____________________________________

22. Type of accident: ____Head-on Collision ____Broadside Collision

____Front Impact ____Rear-end car in front ____Non-collision

23. Describe in your own words what happened to you upon impact:______________

____

____

____

____

____

24. Were photographs taken? ____Yes ____No

If yes, who has photographs? ____

25. Did you give a statement? ____Yes ____No ____Written ____Tape Recorded

If yes, to whom?

Name: ________________________________ Date of Statement __________

What was said? ____

Name: ________________________________ Date of Statement __________

What was said? ____

26. Who has statement(s) now? ____

27. Did you see the accident coming? ____Yes ____No

28. Did you brace for impact? ____Yes ____No

29. Were seatbelts worn? ____Yes ____No

30. Were shoulder harnesses worn? ____Yes ____No

31. Does your car have headrests? ____Yes ____No

32. 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

33. Was your car braking? ____Yes ____No

34. Was your car moving at the time of the accident? ____Yes ____No

35. If yes, how fast would you estimate you were going? ______________mph

36. How fast would you estimate the other car was going? ______________mph

37. 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: _______________

38. At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _______________

39. As a result of the accident, were you

_____Rendered unconscious _____dazed, circumstances vague _______ other

40. Could you move all parts of your body? _____Yes _____No

41. If no, what parts couldn't you move and why? _______________

____

____

42. Were you able to get out of the car and walk unaided? _____Yes _____No

43. If no, why not? _______________

____

44. Did you receive bleeding cuts or bruises? _____Yes _____No

45. If yes, what bleeding cuts did you get from this accident? _______________

46. If yes, what bruises did you get from this accident? _______________

47. Please describe how you felt:

Immediately after the accident: _______________

Later that day: _______________

The next day: _______________

48. Check symptoms apparent since the accident:

_____ Headache	_____ Neck pain/Stiffness	_____ Mid back pain
_____ Eyes light sensitive	_____ Pain behind eyes	_____ Dizziness
_____ Fainting	_____ Sleeping problems	_____ Numbness in fingers
_____ Numbness in toes	_____ Loss of smell	_____ Loss of taste
_____ Loss of memory	_____ Fatigue	_____ Breath shortness
_____ Irritability	_____ Depression	_____ Ringing/Buzzing
_____ Loss of balance	_____ Tension	_____ Cold hands
_____ Cold feet	_____ Diarrhea	_____ Constipation
_____ Chest pain	_____ Nervousness	_____ Cold sweats
_____ Anxious	_____ Other: ______________________	

III. EMPLOYMENT

49. Job Duties: ____

50. Employer Name & Address: ____

____

51. Have you missed time from work? ____ Yes ____ No

52. If yes, full time off work: ____________________ to: ____________________

53. If yes, part time off work: ____________________ to: ____________________

54. Wages at time of accident:

$__________ Hourly rate

$__________ Monthly Income

$__________ Weekly Income

$__________ Commission Income

55. Date returned to work/medical restrictions: ____________________________

56. Previous employers:

Name/Address: ____________________

Dates: ____________________ Job Title ____________________

Supervisor: ____________________ Rate of Pay: ____________________

Reason for leaving: ____________________

Name/Address: ____________________

Dates: ____________________ Job Title ____________________

Supervisor: ____________________ Rate of Pay: ____________________

Reason for leaving: ____________________

IV. MEDICAL TREATMENT

57. Did you seek medical help immediately after the accident? ____Yes ____No

If yes, how did you get there? ____Ambulance ____Police ____Someone else drove me

____Drove own car ____Other: ____________________

58. Were you hospitalized? ____Yes ____No

If yes, name and address of hospital ____________________

PLEASE LIST ALL MEDICAL PROVIDERS (doctors, x-rays, physical therapy, etc. and attach copies of any bills or receipts, including prescriptions)

59. Doctor #1: Name & Address: ____________________

60. First Visit Date: ____________________

61. Were you examined? ____Yes ____No

62. Were x-rays taken? ____Yes ____No

63. Did you receive treatment? ____Yes ____No

64. If yes, what kind of treatment did you receive? ____________________

65. What benefits did you receive from the treatment? ______________________

66. Date of last treatment: ______________________

67. Doctor #2: Name & Address: ______________________

68. First Visit Date: ______________________

69. Were you examined? ____Yes ____No

70. Were x-rays taken? ____Yes ____No

71. Did you receive treatment? ____Yes ____No

72. If yes, what kind of treatment did you receive? ______________________

73. What benefits did you receive from the treatment? ______________________

74. Date of last treatment: ______________________

75. Doctor #3: Name & Address: ______________________

76. First Visit Date: ______________________

77. Were you examined? ____Yes ____No

78. Were x-rays taken? ____Yes ____No

79. Did you receive treatment? ____Yes ____No

80. If yes, what kind of treatment did you receive? ______________________

81. What benefits did you receive from the treatment? ______________________

82. Date of last treatment: ______________________

83. Physical Therapist seen: ______________________

Address: ______________________

(Please use separate sheet for additional doctors if needed)

90. Illustrate below how the accident happened:

Past medical history: Place an (X) if it applies and describe.

____None related to current complaints ____ Hospital or surgery

____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
____Cancer	____Allergy	____Arthritis
____Gout	____Migraines	____Hypertension
____Heart Attack	____Other, list: ________________	

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

____Single ____Married ____Divorced ____Separated ____Widow/Widower

Spouse's name: ____

Dependent____ Age:____________

Dependent____ Age:____________

84. Did you have an attorney on this claim? ____Yes ____No

85. If yes, who? ____

Address: ____

City____________________State________Zip____________Phone ____________

86. List the name and address of ***all*** medical practitioners who examined or treated you for ***any*** mental or physical condition during the past ten (10) years and the condition or complaint the examination or treatment was performed.

Doctor Name, Address & Phone Number **Condition Treated**

____

____

____

____

____

____

87. List any prior lawsuits: ____

88. List all prior accidents: ____

89. What are your present

Needs: ____

Fears: ____

Worries: ____

Congenitals, describe: ____________________

Medications, describe: ____________________

SYSTEM REVIEW

Genito-Urinary System

____Bladder trouble ____Excessive urination ____Scanty urination

____Painful urination ____Discolored urine

Gastro-Intestinal System

____Poor appetite ____Excessive hunger ____Difficult chewing

____Difficult swallowing ____Excessive thirst ____Nausea

____Vomiting food ____Abdominal pain ____Diarrhea

____Constipation ____Black stool ____Bloody stool

____Hemorrhoids ____Liver trouble ____Gall bladder trouble

____Weight trouble

Nervous System

____Numbness ____Loss of feeling ____Paralysis

____Dizziness ____Fainting ____Headaches

____Muscle jerking ____Convulsions ____Forgetfulness

____Confusion ____Depression

Cardio-Vascular System

____Chest pain ____Pain over heart ____Difficult breathing

____Persistent cough ____Coughing phlegm ____Coughing blood

____Rapid heartbeat ____High blood pressure ____Heart problems

____Lung problems ____Varicose veins ____Other

Eye, Ear, Nose, and Throat System

____Eye strain	____Eye inflammation	____Vision problems
____Ear pain	____Ear noises	____Ear discharge
____Hearing loss	____Nose pain	____Nose bleeding
____Nose discharge	____Breathing difficulty	____Sore gums
____Sore mouth	____Sore throat	____Hoarseness
____Speech difficulty	____Dental problems	

Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the attorney 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 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 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 of sleep.

_____ Even when I take tablets, I have less than 4 hours of sleep.

_____ Even when I take tablets, I have less than 2 hours of 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 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 journeys of less than one hour.

_____ Pain restricts me to short necessary trips 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

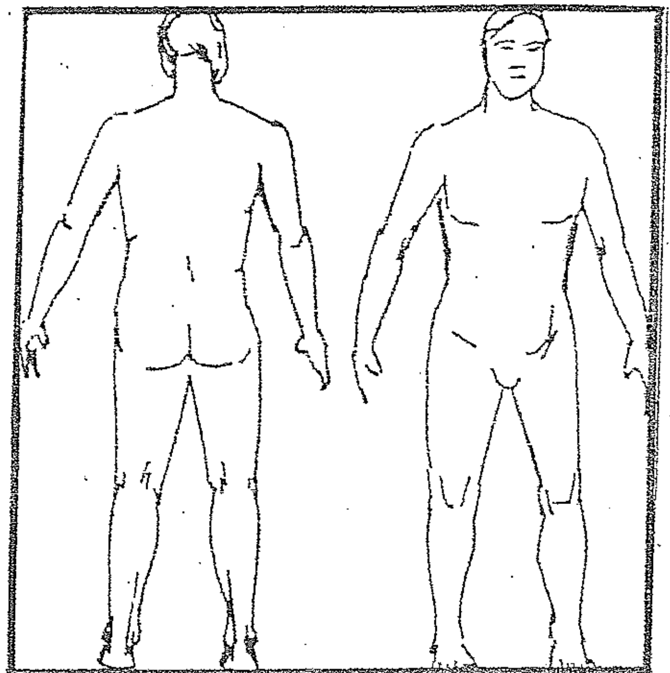
_____ 4 _____ 5 _____ 6

INTENSE PAIN

_____ 7 _____ 8 _____ 9

EMERGENCY

_____ 10



Mark the areas on 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

____
Client Signature