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LAWYER, NEGOTIATOR & PEACEMAKER

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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. ACCIDENT

1. Date of Accident:_____2. Time of Accident:_____a.m./p.m.

2. 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___Written____Tape Recorded:
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?_____

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

43. If no, why not?_____

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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:_____

Illustrate below how the accident happened:

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 ____Breathe 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:_____

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)*

84. Did you have an attorney on this claim?___Yes___No

85. If yes, who?_____

Address:_____

City_____State_____Zip_____Phone_____

<u>Pre-existing Condition</u>: THIS IS IMPORTANT—the insurance company or opposing party will use this information against you. You must inform me about any condition that may or possibly impacts your present complaints.

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:_____

91. **<u>Past medical history</u>**: Place an (X) if it applies and describe.

____Hospital or surgery

____Auto Accident ____Work Accident ____Illness ____Other

Describe:_____

_____

Family History: Place an (X) if nay 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:_____

Medications, describe:_____

SYSTEM REVIEW

Genital-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 light to medium weights 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 ½ mile.

____ Pain prevents me from walking more than ¼ 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 ½ 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 to 10, place an (X) in your current pain level.

NORMAL: _____0

LOW PAIN:_____1 _____2 _____3

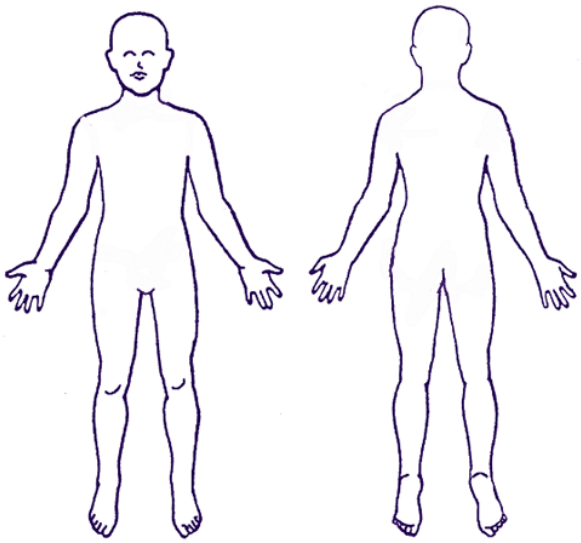
MODERATE PAIN:_____4 _____5 _____6

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 (0)Pin & Needles (=)Stabbing



I SWEART THE INFORMATION CONTAINED HEREIN IS ACCURATE, AND COMPLETE.

_____

Client Signature and date