Accident History Questionnaire

Personal Injury Patient History

Name _____ Date _____

Date of Accident:_____ Time: _____ AM/PM

Driver of car: _____ Owner of car: _____

Year and model of your car: _____

Year and model of other car: _____

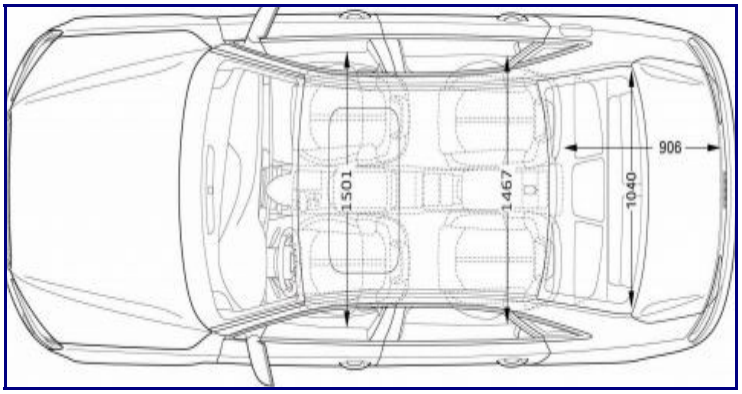
Approximate damage to your car $_____

Visibility at time of accident: □poor □fair □good □other _____

Road conditions: □icy □wet □dry □dark □other _____

Where was your car struck?

Front **Rear**



Type of Accident: □Head-on □Broad-side □Front impact □Rear impact
□Rear-end car in front □Non-collision

Where were you seated: _____

Were seat belts worn: □yes □no Were shoulder harnesses worn? □yes □no

How was the shoulder harness adjusted? □loose □snug

Where air bags deployed? □yes □no Which ones? _____

Did you see/hear the accident coming? □yes □no Did you brace for impact? □yes □no

Were other passengers in your car? □yes □no Were they injured? □yes □no

At the time of impact, what parts of your head or body hit what parts on the inside of your car: _____

Does your car have headrests? □yes □no 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

Headrest horizontal distance from head: _____

Was your car breaking at time of impact? □yes □no

Was your car moving at time of impact? □yes □no

If yes, how fast would you estimate you were going? _____ kph

How fast would you estimate the other car was going? _____ kph

Head/Body position at time of impact:

□Head turned left/right □Body straight in sitting position
□Head looking back□Body rotated right/left

□Head straight forward □Other _____
As a result of the accident were you: □Rendered unconscious □In shock
□Dazed, circumstances vague □Other _____
Were you wearing a hat or glasses? □yes □no
After the accident, could you move all parts of your body? □yes □no
If no, what parts couldn't you move and why? _____
_____
Were you able to get out of the car and walk unaided? □yes □no
If no, why not? _____
Did you get any bleeding cuts? □yes □no If yes, where?_____
Did you get any bruises? □yes □no If yes, where? _____
Please describe how you felt:
Immediately after the accident: _____
_____
Later that day: _____
_____
The next day: _____
_____
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 in ears
□Loss of balance	□Tension	□Cold hands
□Cold feet	□Diarrhea	□Constipation
□Chest pain	□Nervousness	□Cold sweats
□Anxiety	□Low back pain	□Mid back pain

□Other: _____
_____
_____
Occupation: _____ Employer: _____
Have you missed time from work? □yes □no
If yes, full time off work: _____ to _____
If yes, part time off work: _____ to _____
Did you seek medical help immediately after the accident? □yes □no
If yes, how did you get there? □Ambulance □Police □Drove own car
□Someone else drove me □Other _____
Doctor/Facility: Name _____
Visit Date: _____ Were you examined? □yes □no
Were xrays/other imaging studies taken? □yes □no Were you treated? □yes □no
If yes, what kind of treatment did you receive? _____
_____
_____