

Auto Accident Questionnaire

Patient's Name: _____ Date Of Accident: _____ Date: _____

Social History: (please complete the following, check all boxes that apply)

Are you: Married Single Divorced Widowed # of Children: _____ # of Children Living with you: _____

Caffeine: _____ (#of drinks per day) Drinking Alcohol: Never Often Occasional

Social Smoking : _____ (packs per day)

Do you exercise? Yes No If yes, How often _____ (# of times per week) Exercising since accident: Yes No

What type of exercise? _____

Employed: Yes No If employed, Full Time Part Time Occupation: _____

Has accident affected work duties: Yes No If yes, What is affected: _____

Do you feel your weight has affected your symptoms: Yes No If yes, how: _____

Stress Level: _____ Scale 1 to 10 (10 being the worst) Stress Due to: _____

Additional Comments: _____

Past Medical History: (Please check yes or no, If yes, describe incident in the space provided)

Broken Bones: Yes No If yes, please describe: _____

Fractures: Yes No If yes, please describe: _____

Knocked Unconscious: Yes No If yes, please describe: _____

Previous Falls: Yes No If yes, please explain _____

Previous Auto or Work Injuries: Yes No If yes, please explain: _____

Hospitalization: Yes No If yes, please explain: _____

Surgeries: Yes No If yes, please explain: _____

Serious Disease: Yes No If yes, please explain: _____

Additional Comments: _____

History of Injury:

Were you the: Driver Front Seat Passenger Back Seat Passenger On the job at the time of accident

Description of vehicle you were in: Make _____ Model _____ Year _____

Transmission type: Standard (Stick) Automatic

Portion of the vehicle hit: Right Front Left Front Right Rear Left Rear Right Side Left Side

Other: _____

Description of other vehicle: Make _____ Model _____ Year _____

Was the car stopped at the time of the accident? Yes No If you were the driver, was your foot on the brake? Y/N

Was vehicle moving at the time of impact: Yes No If yes, was car Slowing down Gaining speed

Steady rate of speed

Estimated rate of speed? _____ (M.P.H.) Time of day: Daylight Dawn Dusk Dark Unknown

Auto Accident Questionnaire- Continued

Patient's Name: _____ Date of Accident: _____

Road conditions: ___ Dry ___ Damp ___ Wet ___ Snow ___ Ice ___ Other _____

Head Restraints: ___ Up ___ Down ___ Don't know

Seat Position after accident: ___ Was altered ___ Was not altered ___ Don't know

Seat after accident: ___ Broken ___ Not broken

Lap Seatbelt: ___ Worn ___ Not Worn ___ Don't Know ___ Shoulder Seatbelt: ___ Worn ___ Not Worn ___ Don't Know

Air Bag Deployed: ___ Yes ___ No If Yes, were you ___ Struck ___ Not Struck

Body position at time of accident: ___ Good ___ Forward ___ Leaning ___ Other _____ ___ Don't know

Head Position: ___ Forward ___ Left ___ Right ___ Up ___ Down ___ Don't Know ___ Other _____

Hand's on Wheel? ___ Yes ___ No

Aware of Crash: ___ Aware ___ Surprised Did you brace yourself? ___ Yes ___ No If yes, ___ Braced with Arms

___ Braced with Legs

Did this cause further injury: ___ Yes ___ No If yes, please explain _____

During/After Crash:

Patient's body: ___ Jolted ___ Thrown about ___ Stunned ___ Dazed ___ Whipped ___ Slammed ___ Other _____

Did Patient's body strike interior of car: ___ Yes ___ No If yes, please complete all that apply:

My Head hit _____ My ___ Right ___ Left Shoulder hit _____

My ___ Right ___ Left Hip hit _____ My ___ Right ___ Left knee hit _____

My ___ Chest hit _____ My ___ Right ___ Left arm hit _____

My ___ Right ___ Left leg hit _____ My ___ Other body part hit _____

Were you wearing glasses at the time of the accident? ___ Yes ___ No If yes, were the glasses still in place after impact?

___ Yes ___ No

Unconscious? ___ Yes ___ No If yes, unconscious for _____ (# of minutes)

Estimated amount of Property Damage \$ _____

Damage to the other car: ___ minimal ___ moderate ___ major ___ totaled Was anyone cited: ___ Yes ___ No

After accident, I had the following: ___ headache ___ dizziness ___ nausea ___ confusion ___ disorientation ___ neck pain

___ Other _____

Symptoms first appeared: ___ Immediately ___ hours after the accident ___ the next day ___ days after accident # _____

I went: ___ home ___ work ___ hospital ___ family physician ___ other _____

Auto Accident Questionnaire- Continued

Patient's Name: _____ Date of Accident: _____

If you went to the hospital after the accident please complete the following:

Name of hospital: _____

How did you get to hospital? ___ Ambulance ___ Other _____

What body parts were x-rayed, what treatment was given? _____

What did they tell you was wrong? _____

How long did you stay at hospital? _____

Did you sustain bleeding cuts during the accident? ___ Yes ___ No If yes, describe: _____

Did you sustain bruises during the accident? ___ Yes ___ No If yes, describe: _____

Prescribed: ___ Pain Pills ___ Muscle relaxers ___ Anti-Inflammatory ___ Over the counter medications taken: _____

Chief Complaints:

_____ **BACK PAIN** (If checked, please complete the following)

I have pain in my: ___ Lower back ___ Mid back ___ Upper back ___ Pain Between Shoulder Blades

My pain began: ___ Gradually ___ Suddenly I have pain ___ Sometimes ___ Constant ___ Off and On ___ Other _____

How long does the pain usually last: _____ hours _____ days ___ All the time

My pain goes into: ___ Right leg ___ Left leg ___ Both legs ___ I have tingling numbness: ___ Right leg ___ Left leg ___ Both

My pain is worse when I: ___ Cough ___ Sneeze ___ Sit ___ Bend ___ Walk ___ Lift ___ Push ___ Pull ___ Stand for long periods ___ Lie Down

My back is worse with sexual activity: ___ Yes ___ No

Can you describe the sensation: ___ Dull ___ Sharp ___ Throbbing ___ Burning ___ Aching ___ Shooting ___ Constricting ___ Stiff

My pain wakes me up during the night? ___ Yes ___ No Changes in the weather affect my pain? ___ Yes ___ No

How would you describe the intensity? ___ Mild ___ Moderate ___ Severe ___ Comes and goes

Has your condition been: ___ Constant ___ Intermittent Has your condition been: ___ Better ___ Worse ___ About the same

Have you found anything that makes it better? ___ Rest ___ Morning ___ Evening ___ Certain position ___ Other _____

What makes the pain worse: ___ Positions ___ Activities ___ Morning ___ Evening ___ Coughing ___ Sneezing
___ Other _____

Has your condition affected your daily activities in any way? ___ Work ___ Sleep ___ Daily Routine ___ Housework
___ Recreation

If yes to the above, explain:

Have you tried store bought or home remedies: ___ Yes ___ No Explain _____

Did it help? ___ Yes ___ No

Rate pain on a scale of (no pain) 0-10 (worst pain ever): 0 1 2 3 4 5 6 7 8 9 10

Auto Accident Questionnaire- Continued

Patient's Name: _____ Date of Accident: _____

NECK PAIN: (If check, please complete the following)

I have neck pain: Yes No

My pain began: Gradually Suddenly I have pain Sometimes Constant Off and on Other _____

How long does the pain usually last: hours days All the time

My pain goes into my: Right arm Left arm Both arms Other _____

I have tingling and or numbness in my: Right arm Left arm Both arms Right hand Left hand

My pain is worse when I: Sneeze Sit Bend Forward Walk Lift Push Pull Turn Head

Other: _____

Can you describe the sensation: Dull Sharp Throbbing Burning Aching Shooting Constricting

Stiff

My pain wakes me up during the night: Yes No Changes in the weather affect my pain: Yes No

I have neck stiffness: Yes No I have dizziness: None Sometimes

I have headaches: None Sometimes All the time If, yes where are the headaches located: _____

How would you describe the intensity of your pain? Mild Moderate Severe Comes and goes

Has your condition been: Constant Intermittent If yes, explain: _____

Has your condition been: Better Worse About the same

Have you found anything that makes it better? Rest Morning Evening Certain position Other _____

What makes the pain worse: Positions Activities Morning Evening Coughing Sneezing

Other _____

Has your condition affected your daily activities in any way? Yes No If yes, explain: _____

Have you tried store bought or home remedies: Yes No Explain _____

Did it help? Yes No

Rate pain on a scale of (no pain) 0-10 (worst pain ever): 0 1 2 3 4 5 6 7 8 9 10

Auto Accident Questionnaire- Continued

Patient's Name: _____ Date of Accident: _____

_____ **Other Pain:** (If check, please complete the following)

I have pain in my: ___ Right Shoulder ___ Left Shoulder ___ Right Arm ___ Left Arm ___ Right Elbow ___ Left Elbow
___ Right Wrist ___ Left Wrist ___ Right Hip ___ Left Hip ___ Right Knee ___ Left Knee ___ Right Ankle ___ Left Ankle
___ Other _____

My pain began: ___ Gradually ___ Suddenly I have pain: ___ Sometimes ___ Constant ___ Off and on ___ Other _____

The pain usually last: _____ hours _____ days _____ All the time My pain is worse when I: _____

Can you describe the sensation: ___ Dull ___ Sharp ___ Throbbing ___ Burning ___ Aching ___ Shooting ___ Constricting
___ Stiff

My pain wakes me up during the night: ___ Yes ___ No Changes in the weather affect my pain: ___ Yes ___ No

How would you describe the intensity of your pain? ___ Mild ___ Moderate ___ Severe ___ Comes and goes

Has your condition been: ___ Constant ___ Intermittent If yes, explain _____

Have you found anything that makes it better? ___ Rest ___ Morning ___ Evening ___ Certain position ___ Other _____

What makes the pain worse: ___ Positions ___ Activities ___ Morning ___ Evening ___ Coughing ___ Sneezing
___ Other _____

Has your condition affected your daily activities in any way? ___ Yes ___ No If yes, explain: _____

Have you tried store bought or home remedies: ___ Yes ___ No Explain: _____

Did it help? ___ Yes ___ No

Rate pain on a scale of (no pain) 0-10 (worst pain ever): 0 1 2 3 4 5 6 7 8 9 10