

## 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

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

Other Automobile: Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

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

Minor  Major  Totaled

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:  Burning  Sharp  Dull  Ache

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
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

- |  |  |  |  |   |  |
|--|--|--|--|---|--|
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Light Bothers Eyes      | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Head seems too heavy   | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Loss of Memory          | <input type="checkbox"/> Clumsiness          | <input type="checkbox"/> Feet Cold               | <input type="checkbox"/> Neck Stiff            | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> Ears Ring       |
| <input type="checkbox"/> Hands Cold              | <input type="checkbox"/> Sleeping Problems   | <input type="checkbox"/> Tingling in legs/feet   | <input type="checkbox"/> Face Flushed          | <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Back Pain       |
| <input type="checkbox"/> Numbness in arms/hands  | <input type="checkbox"/> Buzzing in Ears     | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Nervousness           | <input type="checkbox"/> Numbness in legs/feet  | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Cold Sweats             | <input type="checkbox"/> Tension             | <input type="checkbox"/> Shortness of Breath     | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Fatigue         |
| <input type="checkbox"/> Irritability            | <input type="checkbox"/> Loss of Smell       | <input type="checkbox"/> Chest pain/rib pain     | <input type="checkbox"/> Pain in arms/hands    | <input type="checkbox"/> Pain in legs/feet      | <input type="checkbox"/> Jaw pain        |
| <input type="checkbox"/> Loss of strength - arms | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Loss of strength - legs | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sharp/shooting pain    |  |

Other \_\_\_\_\_

Have you experienced changes to:

- |                                       |   |                                       |  |                                  |
|---------------------------------------|---|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Eyes (sight) | <input type="checkbox"/> Ears (hearing) | <input type="checkbox"/> Nose (smell) | <input type="checkbox"/> Mouth (taste) | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Bowels       | <input type="checkbox"/> Sleep          | <input type="checkbox"/> Emotion      | <input type="checkbox"/> Appetite      |                                  |

Please Explain: \_\_\_\_\_

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): \_\_\_\_\_

Do you now or have you ever had:

Heart Disease

Diabetes

Cancer

Stroke

High Blood Pressure

Thyroid Problems

Tuberculosis

Prostate Disorder

Kidney Problems

Asthma

Ulcer

Seizure Disorder

Other: \_\_\_\_\_