Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of Accident: _____ 2. Time: _____AM/PM
2. Driver of Car: _____
3. Where were you seated? _____
4. Who owns the car? _____
5. Year & Model of your car. _____
6. Year & Model of other car. _____
7. What was the approximate damage done to your car? $ _____
8. Visibility at time of accident: □ poor □ fair □ good □ other (describe):_____
9. Road conditions at time of accident: □ icy □ rainy □wet □ clear □ dark □other(describe):_____
10. Where was your car struck?

Front  **Back**

In your own words, please describe the accident:_____

_____

_____

11. Type of Collision: □ Head-on □ Broad-side □ Front Impact □ Rear-end car in front
□ Rear impact □ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

_____

13. Did you see the accident coming? □yes □no 14. Did you brace for impact □yes □no
15. Were seatbelts worn? □yes □no 16. Were shoulder harnesses worn? □yes □no
17. Did your airbag deploy? □yes □no 18. Does your car have headrests? □yes □no
19. 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
20. Did your seat break? □yes □no
21. Was your car moving at the time of the accident? □yes □no 22. If yes, how fast were you going?_____
23. How fast was the other car moving at the time of the accident? _____
24. Did you get any bleeding cuts? □yes □no If yes, where? _____
25. Did you get any bruises? □yes □no If yes, where? _____

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26. Head/Body position at the time of impact:

□ Head turned left/right □Head looking back □Head straight forward

□Body straight in seated position □Body rotated right/left □Other: _____

27. As a result of the accident you were:

□ Rendered unconscious □ In shock □ Dazed, circumstances vague □ Other: _____

28. Possibility of head injury? □ yes □ no

29. Could you move all parts of your body? □ yes □ no

30. If no, what parts couldn't you move and why? _____

31. Were you able to get out of the car and walk unaided? □yes □ no

32. If no, why not? _____

33. Did you seek medical help immediately after the accident? □yes □no

34. If yes, how were you transported? _____

35. If no, how did you get home? _____

36. Describe how you felt immediately after the accident: _____

Later that day: _____

The next day: _____

37. Check symptoms apparent since the accident:

□ Headache	□ Chest pain	□ Neck pain/Stiffness	□ Mid back pain
□ Anxious/Nervousness	□ Pain behind eyes	□ Dizziness	□ Low back pain
□ Numbness in fingers	□ Loss of memory	□ Fatigue	□ Loss of balance
□ Irritability	□ Depression	□ Ringing/Buzzing	□ Sleeping problems

□Other _____

38. Have you missed time from work: □yes □no

39. If yes, how much? _____

Illustrate how the accident happened:

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