

# 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? \_\_\_\_\_

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: