PERSONAL HISTORY AUTO ACCIDENT QUESTIONNAIRE

Personal Injury Questionnaire **Patient#__________**

HISTORY OF OCCURRENCE

Name_______________________________________Date__________________________

Date of Accident:_____________________________Time__________________________

Location of Accident (Streets)____

____

As a result of the accident you were:☐ Rendered unconscious ☐ In shock
☐ Dazed, circumstances vague ☐ Shaken Up ☐ Other:___________________________

____

Was your car braking? ☐ Yes ☐ No
Was your car moving at the time of the accident? ☐ Yes ☐ No
How fast was your car going?________________mph (estimate if not sure)
How fast was the other car going?_____________mph (estimate if not sure) ☐Don't know
Driver of your car:____
Year and Model of car you were in:____
Who owns the car?____
Year and model of the other car:____
Where were you seated?____
What was the approximate damage done to your car? $____________________________
Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good ☐ Other:___________________
Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark
Other (describe):____
Where was your car struck? ☐ Front ☐ Rear ☐ Side
Type of accident: ☐ Head-On Collision ☐ Broad-Side Collision ☐ Front Impact
☐ Rear-End car in front ☐ Non-Collision ☐ Rear Impact ☐ Pedestrian
At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:____

____

Did you see the accident coming? ☐ Yes ☐ No
Did you brace for impact? ☐ Yes ☐ No
Were seat belts worn? ☐ Yes ☐ No
Were shoulder harnesses worn? ☐ Yes ☐ No
Does your car have headrests? ☐ Yes ☐ No
If yes, what were the positions 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

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HEAD / BODY POSITION / ABILITY TO MOVE

Head / Body position at the time of impact:

☐ Head turned left / right ☐ Body straight in sitting position
☐ Head looking back ☐ Body rotated right / left
☐ Head straight forward ☐ Other:______________________________

How was the shoulder harness adjusted? ☐ Loose ☐ Snug
Were you wearing a hat or glasses? ☐ Yes ☐ No
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 or bruises? ☐ Yes ☐ No
If yes, what **bleeding cuts** did you get from this accident?__________________________
If yes, what **bruises** did you get from this accident?______________________________
Please describe how you felt immediately after the accident_________________________

____

Later that day:____
The next day:____

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints **just before the accident**? ☐ Yes ☐ No
If yes, what physical symptoms did you have **just before the accident**?_______________

____

PRIOR to this accident, have you **EVER** had symptoms similar to what you're experiencing now? ☐ Yes ☐ No
If yes, please explain (include past falls, injuries, accidents, operations, etc..)

____

____

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	☐ Shortness in breath
☐ Irritability	☐ Depression	☐ Ringing / buzzing in ear
☐ Loss of balance	☐ Tension	☐ Cold hands
☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Chest pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Low Back Pain	☐ Other:________________

____

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WORK STATUS HISTORY

Occupation:____
Employer:____
Employer's Address:____
Employer's Phone Number:____
Supervisor's Name:____
Have you missed time from work: ☐ Yes ☐ No
If yes, full time off work:____
If yes, part time off work:____
☐ I've been unable to work since the accident.

FIRST DOCTOR / HOSPITAL / CLINIC SEEN

Did you seek medical help immediately after the accident? ☐ Yes ☐ No
If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me ☐ Drove own car ☐ Other:_______________________________

Doctor #1: Name:____
Hospital name:____
First visit date:____
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No
Findings / Recommendations:____
Did you receive treatment? ☐ Yes ☐ No
☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive?__________________________
What benefits did you receive from the treatment?_______________________
Date of last treatment:____

Doctor #2: Name:____
Hospital name:____
First visit date:____
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No
Findings / Recommendations:____
Did you receive treatment? ☐ Yes ☐ No
☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive?__________________________
What benefits did you receive from the treatment?_______________________
Date of last treatment:____

Doctor #3: Name:____________________
Hospital name:____________________
First visit date:____________________
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No
Findings / Recommendations:____________________
Did you receive treatment? ☐ Yes ☐ No
☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive?____________________
What benefits did you receive from the treatment?____________________
Date of last treatment:____________________

Do you have an **attorney** on this claim? ☐ Yes ☐ No
If yes, who?____________________
Address____________________
City____________________State__________Zip__________
Phone____________________Fax____________________

Illustrate below how the accident happened.

Describe in your own words how the accident occurred:____________________

____

____

____

____

____

Past Medical History: Place an (X) if it applies and describes:
☐ None related to current complaints ☐ Hospital or Operation
☐ Auto Accident ☐ Work Accident ☐ Illness
☐ Other
Describe:____________________

____

____

PERSONAL HISTORY AUTO ACCIDENT QUESTIONNAIRE

Family History: Place and (X) if any family member does or has suffered from:

- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Spinal Disorder
- ☐ Mental Illness
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Gout
- ☐ Allergies
- ☐ Arthritis
- ☐ Hypertension
- ☐ Cancer
- ☐ Migraines
- ☐ Heart Attack
- ☐ Other, list________________________________

Personal History: Place an (X) if it applies, describe:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower

Number of children:_______________Number of children at home:___________________

Employed Spouse: ☐ Yes ☐ No

Medications, describe:____

Disease, describe:____

Other, describe:____

SYSTEM REVIEW **Place and (X) next to the symptoms you now have*:***

Genito-Urinary System

- ☐ Bladder trouble
- ☐ Excessive hunger
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

Gastro-Intestinal System

- ☐ Poor Appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Weight trouble

Nervous System

- ☐ Numbness
- ☐ Loss of Feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsion
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression

Cardio-Vascular System

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ High blood-pressure
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose Veins
- ☐ Other

Eyes, Ears, Nose and Throat

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Breathing difficulty
- ☐ Sore gums
- ☐ Sour mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Speech difficulty
- ☐ Dental problems

Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the doctor information as to how you pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

SECTION 1 PAIN INTENSITY

☐ The pain comes and goes and is very mild.
☐ The pain is mild and does not vary much.
☐ The pain come and goes and is moderate.
☐ The pain is moderate and does not vary much.
☐ The pain comes and goes and is severe.
☐ The pain is severe and does not vary much.

SECTION 2 PERSONAL CARE (washing, dressing, etc…)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3 LIFTING

☐ I can lift heavy weights without pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

SECTION 4 WALKING

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than ½ mile.
☐ Pain prevents me from walking more than ¼ mile.
☐ I can only walk using a cane or crutches.
☐ I am in bed most of the time, and have to crawl to the toilet.

SECTION 5 SITTING

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than one hour.
☐ Pain prevents me from sitting for more than 30 minutes.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

SECTION 6 STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I can stand as long as I want, but it causes extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using medications or sleeping pills.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 SEX LIFE

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc…).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10 TRAVELING

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to the journeys of less than one hour.
- ☐ Pain restricts me to short necessary trips under ½ hour.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

SECTION 11 CHANGING DEGREE OF PAIN

☐ My pain is rapidly getting better.
☐ My pain fluctuates, but overall is definitely getting better.
☐ My pain seems to be getting better, but improvement is slow at present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Current Chief Complaint(s)

Spine	**Upper Extremity**	**Lower Extremity**
☐ Low Back	☐ Shoulder R L	☐ Hip R L
☐ Mid Back	☐ Arm R L	☐ Thigh R L
☐ Neck	☐ Elbow R L	☐ Knee R L
☐ Pelvis	☐ Wrist R L	☐ Leg R L
	☐ Forearm R L	☐ Ankle R L
	☐ Hand R L	☐ Foot R L

☐ Other (describe)____

Subjective Pain Level

On a scale of 1 to 10, place an (X) in your current pain level.

NORMAL	LOW	MODERATE	INTENSE	EMERGENCY
☐ 0	☐1☐2☐3	☐4☐5☐6	☐7☐8☐9	☐10

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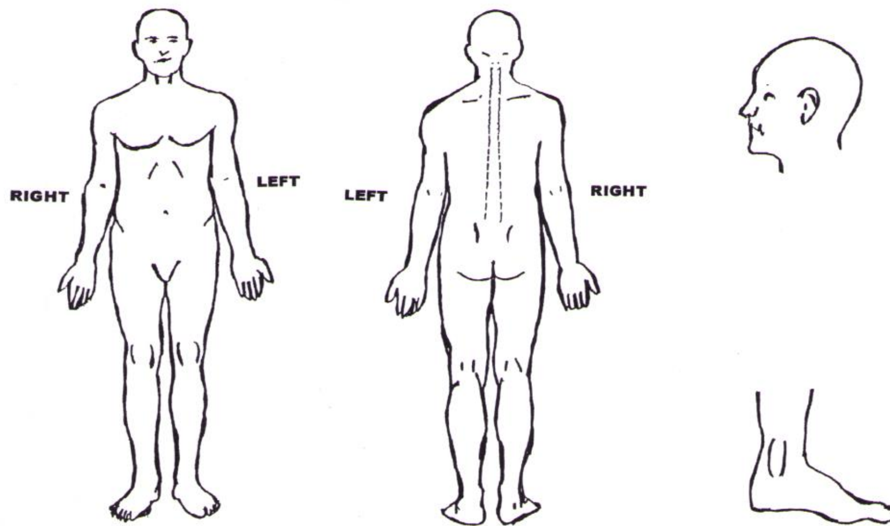
Mark the areas on your body where you feel the described sensations.
Mark stress points of radiation. Include all affected areas.

X	NUMBNESS	+BURNING
0	PINS & NEEDLES	=STABBING



Patients
Signature:____Date:______/______/_______