ACCIDENT HISTORY QUESTIONNAIRE

Name: ______________________________ Date: _____________MR #:_______

1. Date of Accident: _______________ 2. Time: _______________ AM / PM
3. Driver of Car: ____
4. Where were you seated? [ ] Front [ ] Right rear [ ] Left rear
5. Who owns the car? ____
6. Year & Model of your car. ____
   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: ___________
9. Road conditions at time of accident: [ ] icy [ ] rainy [ ] wet [ ] clear [ ] dark
   [ ] other (describe): ____
10. Where was your car struck?

FRONT REAR

11. Type of Accident: [ ] Head-on collision [ ] Broad-side collision [ ] Front Impact
    [ ] Rear-end car in front [ ] Rear impact [ ] Non-collision [ ] other: ______________
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. Does your car have headrests? [ ] yes [ ] no
18. 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
19. Was your car braking? [ ] yes [ ] no
20. Was your car moving at the time of the accident? [ ] yes [ ] no
21. If yes, how fast would you estimate you were going? ____________ mph
22. How fast would you estimate the other car was going? ___________ mph
23. 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: ___________________
24. As a result of the accident you were: [ ] Rendered unconscious [ ] In shock
    [ ] Dazed, circumstances vague [ ] Other: ________________
25. How was the shoulder harness adjusted? [ ] Loose [ ] Snug
26. Were you wearing a hat or glasses? [ ] yes [ ] no
27. Could you move all parts of your body? [ ] yes [ ] no
28. If no, what parts couldn't you move and why? ______________________________
    ____
29. Were you able to get out of the car and walk unaided? [ ] yes [ ] no
30. If no, why not? ____
31. Did you get any bleeding cuts? [ ] yes [ ] no If yes, where? __________________
32. Did you get any bruises? [ ] yes [ ] no If yes, where? _______________________
33. Please describe how you felt:
    Immediately after the accident: ____

ACCIDENT HISTORY QUESTIONNAIRE

Name: __________________________ MR#: _____ DOB: _________ Date: _________

Later that day: ____

The next day: ____

34. 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	[ ] Head seems too heavy
[ ] Loss of memory	[ ] Fatigue	[ ] Shortness of breath
[ ] Irritability	[ ] Depression	[ ] Ringing/Buzzing in ears
[ ] Loss of balance	[ ] Tension	[ ] Cold Hands
[ ] Cold feet	[ ] Diarrhea	[ ] Constipation
[ ] Chest pain	[ ] Nervousness	[ ] Cold Sweats
[ ] Anxious	[ ] Facial pain	[ ] Clicking or Popping Jaw
[ ] Low Back Pain	[ ] Other: _______________________________________	

____

35. Have you missed time from work: [ ] yes [ ] no
36. If yes, full time off work: ____________________ to ______________________
37. If yes, part time off work: ____________________ to _____________________
38. Did you seek medical help immediately after the accident? [ ] yes [ ] no
39. If yes, how did you get there? [ ] Ambulance [ ] Police
    [ ] Someone else drove me [ ] Drove own car [ ] Other: ____________________
40. Doctor #1: Name: ____
41. First Visit Date: ____
42. Were you examined? [ ] yes [ ] no
43. Were X-rays taken? [ ] yes [ ] no
44. Did you receive treatment? [ ] yes [ ] no [ ] Medications [ ] Braces [ ] Collars
45. If yes, what kind of treatment did you receive? ____________________________________
46. What benefits did you receive from the treatment? _________________________________
47. Date of last treatment: ____
48. Doctor #2: Name: ____
49. First Visit Date: ____
50. Were you examined? [ ] yes [ ] no
51. Were X-rays taken? [ ] yes [ ] no
52. Did you receive treatment? [ ] yes [ ] no [ ] Medications [ ] Braces [ ] Collars
53. If yes, what kind of treatment did you receive? ____________________________________
54. What benefits did you receive from the treatment? _________________________________
55. Date of last treatment: ____
56. Do you have an attorney on this claim? [ ] yes [ ] no
57. If yes, who? ____
    Address: ____
    City: ___________________ State: _____ Zip: ________ Phone: ______________
58. Name of your Insurance Company involved? ____________________________________
59. Name of Insurance Company of person responsible for injuries: ______________________
60. Have you been contacted by an insurance Adjuster or Company Representative regarding this claim? [ ] yes [ ] no