Motor Vehicle Accident **Questionnaire**

## PERSONAL INJURY PATIENT HISTORY

**Name** _____ **Date** _____

**Address** _____ **Phone** _____

**Cell Phone** _____ **E-Mail** _____

**For text reminders, your cell phone provider:** _____

**Date of Birth:** _____ **Social Security Number:** _____

**WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN**

**Date of the accident:** _____ **Time:** _____ AM PM

**What city did the accident take place in?** _____

**Driver of vehicle:** _____ **Where were you seated?** _____

**Who owns the vehicle?** _____

**Number of people in the vehicle:** _____

**Year & Model of your vehicle:** _____

**Year & Model of the other vehicle:** _____

**What was the approximate damage done to <u>your</u> vehicle? $** _____

**Do you have photographs of the damaged vehicle?** Yes No **Are you in the photos?** Yes No

**Can you see the damage from 20 feet away?** Yes No

**Visibility at the time of the accident:** ( ) Poor ( ) Fair ( ) Good ( ) Other

**Road conditions at time of the accident:** ( ) Icy ( ) Rainy ( ) Wet ( ) Clear ( ) Dark

**What direction were you headed?** ( ) North ( ) South ( ) East ( ) West

**What direction as the other vehicle headed?** ( ) North ( ) South ( ) East ( ) West

**Were you struck from:** ( ) Behind ( ) Front ( ) Left side ( ) Right side

**How many impacts occurred?:** _____

**Please describe:** _____

**<u>Important</u>: Does your vehicle have a tow bar?** Yes No

**In your own words please describe the accident:** _____

_____

**Type of collision:** ( ) Head-on ( ) Broad-side ( ) Front impact ( ) Rear-end car in front ( ) Rear impact ( ) Non-collision

**Body strike: At the time of the accident, recall what parts of your head or body hit what parts on the inside of your vehicle:**

_____

**Were you aware of impending impact?** Yes No → **Did you brace for impact?** Yes No

**Did you have your seatbelt on?** Yes No → **Were shoulder harnesses worn?** Yes No

**Does your vehicle have headrests?** Yes No

**If yes, what was the position of those headrests compared to your head before the accident?**

( ) Top headrest even with bottom of the head ( ) Top headrest even with top of the head ( ) Top of headrest even with the middle of the neck

**Was your vehicle braking?** Yes No

**Was your vehicle moving at the time of the accident?** Yes No

**How fast would you estimate you were going**? _____ mph **The other vehicle?** _____ mph

**Head position at time of impact:**

( ) Turned right ( ) Turned left ( ) Straight forward ( ) Looking back ( ) Looking at mirror ( ) Not applicable

*If looking at mirror:* ( ) Driver side mirror ( ) Passenger mirror ( ) Rearview mirror

**Body position at time of impact:**

( ) Body straight in sitting position ( ) Body rotated right ( ) Body rotated left

Other: _____

**As a result of the accident, you were:**

( ) Knocked unconscious ( ) In shock ( ) Dazed, circumstances vague 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 vehicle and walk unaided?** Yes No

**If not, why?** _____

**Did you get any bleeding cuts?** Yes No If yes, where? _____

**Did you get any bleeding scrapes?** Yes No If yes, where? _____

**Did you get any bruises?** Yes No If yes, where? _____

**If you sustained visible injuries as a result of the accident, do you have photographs of the injuries?** Yes No

**When did the pain start?** _____

**Describe how you felt immediately after the accident:** _____

**Later that day:** _____

**The next day:** _____

**Circle symptoms apparent since the accident:**

| | | | | |
|---|---|---|---|---|
| Headache | Chest pain | Neck pain/stiffness | Mid back pain | Light sensitivity |
| Anxious/Nervousness | Pain behind eyes | Dizziness | Low back pain | Sleeping problems |
| Numbness in fingers | Loss of smell | Numbness in toes | Fainting | Cold feet |
| Facial pain | Loss of memory | Fatigue | Breath shortness | Loss of taste |
| Irritability | Depression | Ringing/Buzzing | Cold sweats | Loss of balance |

Tension Constipation Cold hands Clicking/Popping Jaw Diarrhea

Other: _____

**Occupation:** _____ **Employer:** _____

**Have you missed time from work?** Yes No

**If yes, full time off work:** _____ **to** _____

**If yes, part time off work:** _____ **to** _____

**Were police notified at the time of the accident?** Yes No

**Did you seek medical help after the accident?** Yes No

**If yes, did you see:** ( ) MD ( ) ER ( ) Urgent Care **When?** _____

**If yes, how did you get there**? ( ) Ambulance ( ) Police ( ) Someone drove me ( ) I drove myself

**Important: Were you transported on a back board?** Yes No

**Did the accident force you to take any medications?** Yes No **If so, what:** _____

**Name of Doctor #1:** _____ **First Visit Date:** _____

**Were you examined?** Yes No **Were X-rays taken?** Yes No

**Did you receive treatment?** Yes No → **Select one if applicable:** ( ) Medications ( ) Braces ( ) Collars

**If yes, what kind of treatment did you receive?** _____

**What benefits did you receive from the treatment?** _____

**Date of last treatment:** _____

**Name of Doctor # 2:** _____ **First Visit Date**: _____

**Were you examined?** Yes No **Were X-rays taken?** Yes No

**Did you receive treatment?** Yes No → **Select one if applicable:** ( ) Medications ( ) Braces ( ) Collars

**If yes, what kind of treatment did you receive?** _____

**What benefits did you receive from the treatment?** _____

**Date of last treatment:** _____

**Did the car that hit you have insurance?** Yes No

**Illustrate how the accident happened.**

**Have you had any previous related motor vehicle accidents?** Yes No

**If yes:**

**Date of Accident #1: _____ Please describe below:**

_____

_____

**Date of Accident #2: _____ Please describe below:**

_____

_____

**Date of Accident #3: _____ Please describe below:**

_____

_____

**OTHER AUTO INFORMATION:**

**Did a police officer write up a police report on the accident?**

▫ YES ▫ NO

**Do you have a copy of the police report?**

▫ YES ▫ NO (if yes, please provide our office with a copy of this report)

**Was a ticket or citation issued by a police officer as a result of the accident?**

▫ YES ▫ NO Who received the ticket or citation? _____

**Do you have any information, including insurance information, concerning the other parties involved in the accident?**

▫ YES ▫ NO (If yes, please provide our office with a copy of this information)

**Did the accident involve a hit-and-run driver?**

▫ YES ▫ NO

**Are you, yourself, licensed to drive?**

▫ YES ▫ NO (please provide our office with a copy of your license)

**Was the car in which you were at the time of the accident registered**? ▫ YES ▫ NO (please provide a copy of the registration)

Other:_____

**Were you in your own vehicle or someone else's at the time of the accident? Check one.**

▫ My own vehicle ▫ my spouse's ▫ my parent's ▫ a friend's ▫ other

**If you were in someone else's vehicle, answer the following:**

Name of Owner: _____

Address of Owner: _____

**Do you reside with a family member who owns their own vehicle or is insured under some other auto policy? – Automobile insurance laws in applicable states require this info (check all that apply)**

▫ Spouse ▫ Father ▫ Mother ▫ Guardian / Foster Parent ▫ Grandparent ▫ Sister / Brother ▫ Child ▫ None

Your Auto Insurance Company (at the time of accident): _____ Phone or City: _____

Agent:_____ Phone or City: _____

**Was there any property damage to either of the vehicles as a result of the accident?**

▫ both vehicles ▫ the other person's vehicle ▫ the vehicle I was in ▫ Neither vehicle was damaged

**Have you been contacted by an adjuster from the other party's insurance company regarding this claim?**

▫ YES ▫ NO

Adjuster: _____ Company: _____Phone: _____

**Check all that apply:**

▫ I have settled my personal injury claim with this company

▫ I have settled the property damage claim

▫ I have signed an agreement which will pay my medical expenses for a period of time (explain):

_____

▫ I have not signed any agreement, nor settled any portion of my claim.

**Do you have an attorney on this claim?** YES NO

If yes, who? _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

**PAST MEDICAL HISTORY - Circle if any past medical history applies and describe:**

( ) None related to current complaints ( ) Hospital or operation ( ) Work Accident ( ) Illness ( ) Other

**Describe:** _____

**FAMILY HISTORY- Circle if any family history applies:**

| | | | | |
|---|---|---|---|---|
| Tuberculosis | Kidney disease | Spinal disorder | Mental Illness | Epilepsy |
| Diabetes | Gout | Allergy | Arthritis | Hypertension |
| Cancer | Migraines | Heart Attack | Other, list: _____ | |

**PERSONAL HISTORY**

( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widow/Widower

**Employed Spouse?** ( ) Yes ( ) No

**Number of children:** _____ **Number of children at home:** _____

**Are you pregnant?** ( ) Yes ( ) No ( ) Unsure

**Medications, describe:** _____

**Disease, describe:** _____

**Other, describe:** _____

## SYSTEM REVIEW - Circle the symptoms you know you have:

### GENITO-URINARY SYSTEM

Bladder trouble | Excessive urination | Scanty urination | Painful urination | Discolored urine

### GASTRO-INTESTINAL SYSTEM

Poor appetite | Excessive hunger | Difficulty chewing | Difficulty swallowing | Excessive thirst

Nausea | Vomiting food | Abdominal pain | Diarrhea | Constipation

Black stool | Bloody stool | Hemorrhoids | Liver trouble | Weight trouble

Gall bladder trouble

### NERVOUS SYSTEM

Numbness | Loss of feeling | Paralysis | Dizziness | Fainting | Muscle jerking

Convulsions | Forgetfulness | Confusion | Depression | Headaches

## SYSTEM REVIEW (CONTINUED) - Circle the symptoms you know you have:

### CARDIO-VASCULAR SYSTEM

Chest pain | Pain over heart | Difficult breathing | Persistent cough | Coughing blood

Coughing phlegm | Rapid heartbeat | High blood pressure | Heart problems | Lung problems

Varicose veins | Other: _____

### EYES, EARS, NOSE & THROAT SYSTEM

Eye strain | Eye inflammation | Vision problems | Ear pain | Ear noises

Ear discharge | Hearing loss | Breathing difficulty | Nose bleeding | Nose discharge

Sore gums | Nose pain | Sore mouth | Sore throat | Hoarseness

Speech difficulty | Dental problems

## CURRENT CHIEF COMPLAINTS - Circle the appropriate complaint areas and <u>which side</u>, if applicable:

### SPINE

Low back | Mid back | Neck | Pelvis

### UPPER EXTREMITY

Shoulder ( ) R ( ) L  Arm ( ) R ( ) L  Elbow ( ) R ( ) L  Wrist ( ) R ( ) L

Forearm ( ) R ( ) L  Hand ( ) R ( ) L

**LOWER EXTREMITY**

Hip ( ) R ( ) L Thigh ( ) R ( ) L Knee ( ) R ( ) L Leg ( ) R ( ) L

Ankle ( ) R ( ) L Foot ( ) R ( ) L

**OTHER** describe: _____

**SUBJECTIVE PAIN LEVEL - On a scale of 1 to 10, circle your current pain level:**

**Normal ← 1 2 3 4 5 6 7 8 9 10 → Emergency**

**Patient Signature:** _____ **Date:** _____