PERSONAL INJURY / ACCIDENT QUESTIONNAIRE

NAME: _____ **DATE:** _____

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

Describe the accident in your own words: _____

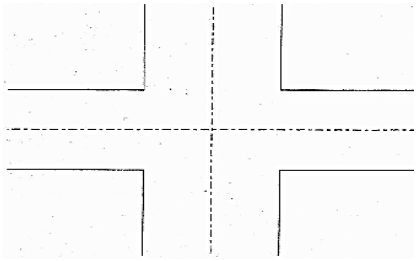
_____

_____

Where did the accident happen? _____

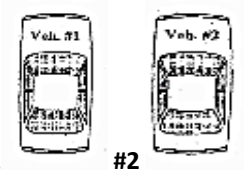
Did the police come to the accident scene? ___Yes ___No

Please complete the drawing (include who hit whom, and what part of vehicle was impacted).



Vehicle #1—Yours

Type _____
Speed_____
$ Damage_____



#1 **#2**

Vehicle #2—Other

Type_____
Speed_____
$ Damage_____

PLEASE CHECK ALL THAT APPLY, OR WRITE IN ADDITIONAL INFORMATION

What were you? ___Driver ___Passenger

What was your position in the car? ___Front left ___Front right ___Rear left ___Rear middle ___Right rear

How many persons were in the vehicle? ___1 ___2 ___3 ___4 ___5 ___6

Describe briefly the relationship of the others to you and their injuries: _____

_____

_____

Road conditions: ___Dry ___Wet ___Ice/Snow ___Pavement ___Gravel ___Dirt

At the time of impact, were you looking straight ahead? ___Yes ___No

If no, which way were you turned and how much? _____

Were you aware and able to brace for the impact? ___Yes ___No

Were both hands on the steering wheel? ___Yes ___No

Was your foot on the brake? ___Yes ___No

Were you wearing a seatbelt? ___Lap belt only ___Shoulder type ___None

How far is the top of the headrest or seat from the back of your head?

___Above the head ___Below the head ___Same level as head

Where in the car were you after the accident? _____

-OVER-

Did any part of your body strike any part of the vehicle? _____

Immediately following the accident, how did you feel? _____

_____

Did you sustain any bleeding or bruising? ___Yes ___No

If yes, please explain _____

Were you unconscious? ___Yes ___No Dazed? ___Yes ___No

What are your symptoms?

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**
6. **_____**

Do you have any numbness or tingling in your arms? ___Yes ___No

What makes your symptoms worse? _____

What makes your symptoms better? _____

Did you go to a hospital? ___Yes ___No

Name of facility? _____

How did you get there? _____

How long after the accident did you go there? _____

Attending Doctor's name? _____

What was done? _____

What treatment was recommended? _____

Have you seen any other doctor? ___Yes ___No Doctor's name? _____

Briefly, what was done or recommended? _____

_____

List all days you have lost from work since this accident_____

_____

Previous to this accident, have you ever had the same or similar symptoms as you do now? ___Yes ___No

If yes, please explain_____

Do you work? ___Full-time ___Part-time ___Other _____

What is your occupation/daily responsibilities? _____

How has this accident restricted you from your daily activities/work? _____

_____

What is your approximate height? _____ Weight? _____

Patient Signature _____ Date: _____