ACCIDENT HISTORY QUESTIONNAIRE

TODAY'S DATE: _______________________

Last Name __________________________ First Name __________________________ DOB: __________

PERSONAL INJURY PATIENT HISTORY

Date of Accident: ______________________ Time of day ______________________ AM/PM

Driver of Vehicle: __________________________
Who owns the car: __________________________
Where were you seated: ______________________
Year and Model of vehicle: ______________________
Approximate Damage to vehicle: _________________
Other vehicle make/model: ______________________
Visibility at time of accident: ______________________
☐ Poor ☐ Fair ☐ Good ☐ Other ______________________
Road condition at time of accident: ______________________
☐ Icy ☐ Rainy ☐ Wet ☐ Clear ______________________
☐ Dark ☐ Other ______________________
Where was your car struck: ☐ Right ☐ Left ______________________
☐ Rear ☐ Front ☐ Side ☐ Other ______________________
Type of Accident: ☐ Head-on collision ______________________
☐ Broad Side collision ☐ Front impact ______________________
☐ Rear end collision ☐ Non-collision ______________________
Describe in your own words what happened to you upon impact: ______________________

Head/Body position at time of impact:
☐ Head turned left/right ______________________
☐ Body straight in sitting position ______________________
☐ Head looking back ______________________
☐ Body rotated left/right ______________________
☐ Head straight forward ______________________
☐ OTHER ______________________

At time of accident recall what parts of your head or body hit parts of the inside of the car: ______________________

As a result of the accident were you:
☐ Rendered Unconscious ______________________
☐ Dazed, circumstances vague ______________________
☐ Other: ______________________

Could you move all parts of your body? ______________________
☐ YES ☐ NO ______________________
If no, what parts could you not move and why? ______________________

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No ______________________
If No, why not? ______________________

Did you get bleeding cuts or bruises? ☐ Yes ☐ No ______________________
If yes, where? ______________________

Please describe how you felt:
Immediately after the accident: ______________________
Later that day: ______________________

________________________
ACCIDENT HISTORY QUESTIONNAIRE

Patient Name: ________________________________ Date of Birth: _________________

Check symptoms apparent since the accident:
☐ Headache  ☐ Neck pain/stiffness  ☐ Mid Back Pain  ☐ Eyes light sensitive
☐ Pain behind eyes  ☐ Dizziness  ☐ Fainting  ☐ Sleeping problems
☐ Numb fingers  ☐ Numb Toes  ☐ Loss of Smell  ☐ Loss of taste
☐ Loss of memory  ☐ Shortness of Breath  ☐ Irritability  ☐ Ring/buzz in ears
☐ Depression  ☐ Fatigue  ☐ Loss of Balance  ☐ Tension
☐ Cold Hands  ☐ Cold feet  ☐ Diarrhea  ☐ Constipation
☐ Chest Pain  ☐ Nervousness  ☐ Cold Sweats  ☐ Low back pain
☐ Other: ______________________________________

Occupation: ________________________________ Employer: ______________________

Have you missed time from work? ☐ Yes ☐ No  If Yes, days/hours missed? __________

Did you seek medical help immediately after the accident? ☐ Yes ☐ No

If yes, how did you get there? ________________________________

At what facility were you treated? ________________________________ Dr. Name: __________

Fist visit date: _________________ Were you examined? ☐ Yes ☐ No  Were X-Rays taken? ☐ Yes ☐ No

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, Name of Attorney: ________________________________ Phone #: ________________

INSURANCE INFORMATION

Was a police report filed? ☐ Yes ☐ No  Do you have a copy? ☐ Yes ☐ No

OTHER VEHICLE’S INSURANCE:

Driver of other vehicle: ___________________________ Their insurance company: __________

Policy#: ___________________________ Claim#: ___________________________

Adjuster’s Name: ___________________________ Phone#: ___________________________

INSURANCE OF DRIVER OF VEHICLE YOU WERE IN:

Insurance Co.: ___________________________ Insured Named: ___________________________

Policy#: ___________________________ Claim#: ___________________________

Adjuster/Agent Name: ___________________________ Phone#: ___________________________

Do you have Medical Payments Coverage? ☐ Yes ☐ No  Do you have Uninsured Motorists? ☐ Yes ☐ No

Your Insurance Company: ___________________________ Policy #: ___________________________

Claim#: ___________________________ Adjuster/Agent Name: ___________________________ Phone#: ___________________________

Do you have Health Insurance Coverage? ☐ Yes ☐ No  Insurance Company: ___________________________

ID#: ___________________________ Group# ___________________________ Phone#: ___________________________