ACCIDENT HISTORY QUESTIONAIRE

IMPACT CLINIC
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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: _____
_____

Did you see the accident coming? □Yes □No
Did you brace for impact? □Yes □No
Were you wearing your seatbelt? □Yes □No
Does the car have headrests? □Yes □No
Was your car braking? Yes □No
Was your car moving at time of accident? □Yes □No
If yes, how fast would you estimate you were going?
_____ mph
How fast do you estimate the other car was going?
_____ mph

Head/Body position at time of impact:
□ Head turned lef/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 QUESTIONAIRE

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#: _____