Accident History Questionnaire

Name:_____ Date:_____

Date of Accident:_____ Time:_____ AM/PM

Driver of Vehicle: ☐ Self ☐ Other:_____

Where were you seated:_____

The vehicle is owned by:_____

Year/Make/Model of the vehicle you were in:_____

Year/Make/Model other vehicle(s) involved:_____

Visibility at time of accident: ☐Poor ☐Fair ☐Good ☐Other:_____

In your own words, please describe accident:_____

_____

_____

Type of collision: ☐head-on ☐broad-side ☐front impact ☐rear impact ☐none

Did any parts of your head or body hit anything inside the vehicle? Y/N

Explain: _____

Seatbelts worn? Y/N Was your car in motion or stopped? Moving/Stopped

Head/Body position at the time of impact:

*Head- ☐ turned left/right ☐ looking back ☐ straight forward
☐ other:_____

*Body- ☐ straight in sitting position ☐ rotated left/right
☐ other:_____

As a result of the accident, you were:
☐ Unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other_____

Please describe how you felt:

*Immediately after the accident:_____

*Later that day:_____

*The next day:_____

Occupation:_____

Have you missed time from work: Y/N How long:_____

Check symptoms apparent since accident:

- ☐ Headaches
- ☐ Dizziness
- ☐ Pain Behind Eyes
- ☐ Numbness in toes
- ☐ Loss of memory
- ☐ Irritability
- ☐ Loss of balance
- ☐ Cold feet
- ☐ Chest pain
- ☐ Anxious
- ☐ Low back pain
- ☐ Neck pain/Stiffness
- ☐ Fainting
- ☐ Sleeping problems
- ☐ Loss of smell
- ☐ Fatigue
- ☐ Depression
- ☐ Tension
- ☐ Diarrhea
- ☐ Nervousness
- ☐ Facial pain
- ☐ Other: _____
- ☐ Mid back pain
- ☐ Eyes Light Sensitive
- ☐ Numbness in fingers
- ☐ Loss of taste
- ☐ Breath shortness
- ☐ Ringing/Buzzing
- ☐ Cold hands
- ☐ Constipation
- ☐ Cold sweats
- ☐ Clicking/Popping jaw

Did you go to the hospital: Y/N

When: ☐ Same day ☐ Next day ☐ Other: _____

Were you taken by ambulance: Y/N Were you admitted: Y/N

If you did not go, did you seek any other medical help: Y/N

Explain: _____

I have filled out this form accurately and truthfully to the best of my ability.

_____ _____

Patient Signature Date