ACCIDENT INJURY CLINIC

Accident Questionnaire

General Information

Name: _____ **Date of accident:** _____ **Police report?** ❑ Yes ❑ No

Model/Yr. of Vehicle: _____ **Estimated vehicle damage: $** _____ **Was vehicle towed?** ❑ Yes ❑ No

- **Were you the:** ❑ Driver ❑ Front Passenger ❑ Rear Passenger
- **What type of accident?** ❑ Head-on ❑ Front Impact ❑ Rear Impact ❑ Broad-sided (Driver / Passenger)
  ❑ Multiple Impact (please describe: _____)
- **At impact, what was the speed of YOUR vehicle:** _____mph **OTHER Vehicle:** _____mph
- **Type of restraint:** ❑ Lap Belt & Shoulder Harness ❑ Lap Belt Only ❑ None:
- **Was your vehicle equipped with airbags?** ❑ Yes ❑ No
  If yes, did your airbag inflate? ❑ Yes ❑ No
- **Were you aware of the impending accident?** ❑ Yes ❑ No
- **Did you brace for impact?** ❑ Yes ❑ No
  What did you brace with? ❑ Arms ❑ Feet
- **What was the position of your head/body at the time of impact?**
  ❑ Head straight ❑ Head Turned Left ❑ Head Turned Right
  ❑ Body Straight ❑ Body Rotated Left ❑ Body Rotated Right
- **Did your head/body contact the inside of the vehicle at impact?** ❑ Yes ❑ No
  If yes, what did your head/body contact? ❑ Windshield ❑ Headrest ❑ Steering Wheel
  ❑ Side Window ❑ Dashboard ❑ Other _____
- **Was your neck / body thrown?** ❑ Forward and Backward ❑ Side-to-side

Symptoms / Injuries

What symptoms have you experienced since your accident?

❑ Neck Pain
❑ Neck Restriction
❑ Arm Pain ❑ Left ❑ Right
❑ Middle Back Pain
❑ Lower Back Pain
❑ Lower Back Restriction
❑ Leg Pain ❑ Left ❑ Right
❑ Bruising (location) _____
❑ Bleeding/Cuts (location) _____

❑ Headache
❑ Dazed / Confused
❑ Dizziness
❑ Nausea / Vomiting
❑ Visual Disturbances
❑ Ringing / Buzzing in ears
❑ Work / Daily Activities / School increase pain (circle)
❑ Other _____

❑ Loss of Consciousness
❑ Chest Pain
❑ Shortness of Breath
❑ Fatigue
❑ Anxiety
❑ Depression

- **Rate your pain on a scale of 1-10 (1=Mild, 10=Severe)** 1 2 3 4 5 6 7 8 9 10
  Since the accident, is the pain? ❑ Better ❑ Worse ❑ Same

Emergency Treatment

- **Did you seek medical attention immediately?** ❑ Yes ❑ No
  If yes, where did you seek medical attention? _____
- **How did you get there?** ❑ Ambulance ❑ Drove self ❑ Someone else drove ❑ Other
- **Were you examined?** ❑ Yes ❑ No **Doctor:** _____
- **Did you receive any of the following?** ❑ Collar ❑ Stitches ❑ X-Rays (list) _____
  ❑ Hospital Stay ❑ Surgery ❑ Medication **Testing:** ❑ CT ❑ MRI ❑ Other _____

BY SIGNING BELOW I ACKNOWLEDGE THAT THE INFORMATION PROVIDED ABOVE IS BOTH ACCURATE AND COMPLETE.

_____ _____
Signature of Patient / Legal Guardian and Relationship to Patient **Date**

_____
Printed Name of Patient / Legal Guardian