Automobile Accident Questionnaire

Please answer all questions completely

Name _____ Sex_____ Marital Status_____ Date of Birth_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Occupation_____ Email _____
(Indicate if child, student, housewife, unemployed, retired)

Date of accident: _____ Time of accident: _____ Driver / Passenger / Pedestrian (Circle one)

Location of accident: _____ Direction you were traveling N S E W

What kind of vehicle were you driving? _____ Struck By? _____

History of accident: ____Stopped and rear-ended ____ Hit head on ____ Other car ran stop sign or red light ____ Lost control
Other_____

Please explain in detail how your accident happened: _____
_____
_____
_____

Were you wearing your seatbelt? ____Yes ____No Did airbags deploy? ____Yes ____No

What were the road conditions at the time of the accident? ____Clean and Dry ____Raining ____Wet ____Other_____

Did you Strike any object inside the car? ____Yes ____No
____Steering Column ____Rearview Mirror ____Dash Board ____Headrest ____Side Window ____Door Panel
____Windshield ____Seat Broke ____ Other_____

What portion of your body did you hit? ____Head ____Face ____Chest ____Arms ____Legs ____Knees ____Other_____
Please describe:_____

Where did you feel pain immediately after the accident? ____Head ____Neck ____Upper Back ____Middle Back ____Lower back
____Arms ____Legs ____Other_____

What are your present complaints?_____
_____
_____

Check symptoms you have noticed since the accident:

__Headache	__Cold Sweats	__Depression	__Fatigue
__Stomach Upset	__Light Bothers Eyes	__Buzzing in Ear	__Diarrhea
__Neck Pain	__Head seems too Heavy	__Loss of Memory	__Cold Feet
__Neck Stiff	__Pins and Needles in Arms	__Ringing in the ears	__Cold Hands
__Back Pain	__Shortness of Breath	__Weight Loss	__Muscle Tone
__Fainting	__Sleeping Problems	__Loss of Balance	__Dizziness
__Face Flushed	__Pins and Needles in Legs	__Constipation	__Tension
__Nervousness	__Numbness in Fingers	__Loss of Smell or taste	__Fever
__Irritability	__Numbness in Toes	__Chills	Other_____

Please describe any other problems or symptoms you are experiencing including, but not limited to, your eyes, ears, nose, throat, cardiovascular, respiratory, gastrointestinal, genitalia, groin, skin, breasts or buttocks_____
_____

Were you ____Unconscious _____Cut _____Bleeding? If cut or bleeding what part(s) of your body?_____

Do you have any bruises? ____Yes ____No If yes, on what part(s) of your body? _____

Where were you taken after the accident? ____ Return Home ____Return to Work _____Other_____
Hospitalized? _____Yes _____No if yes, admitted? _____How long did you stay? _____
Name of Hospital _____
Name of Doctors _____
What treatment was given? ____Examination ____X-Rays ____Prescription _____Cervical Collar _____Stitches _____Other_____

Was any other doctor consulted after your accident? ____Yes ____No
If so, what was the doctor's name? _____ ____D.C. ____M.D. ____D.O. ____D.D.S.
What was the diagnosis? _____
What treatment was given? _____
How often did you see the doctor? _____
How long did you see the doctor? _____

Have you ever had any complaints on the involved area before? _____Yes ____No
If so, what were the complaints? _____
_____

Since this injury are your symptoms _____Improving _____Getting worse _____Staying the same

Before the injury were you capable of working on an equal basis with others your age? _____Yes ____No

Are your work activities restricted as a result of this accident? ____Yes ____No
If yes, please explain: _____

Have you missed any work as a result of this accident? ____Yes ____No
If yes, what dates? _____

Since the accident, have been **Unable** to: ____Sleep well ____Exercise ____Drive ____Resume daily activities ___Other_____

Since the accident are you: ____Bedridden ____Walking with a limp ____Having psychological side effects ____Having anxiety
____Having anxiety while driving ____In need of assistance from a walker, wheelchair, cane or crutches
____Able to return to work ____Working with restrictions or light duty

Prior major illnesses, injuries, operations, and hospitalizations? _____
_____

Sexually active? ____Yes ____No Problems with eating or diet? ____Yes ____No

Do you use drugs, alcohol or tobacco? ____Yes ____No If so, how often _____

Do you have an attorney representing you? ____Yes ____No
If yes, please write your attorney information below:
Name: _____
Address: _____
_____
Phone #: _____

Additional Comments: _____
_____
_____
_____
_____