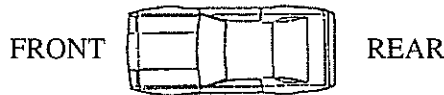


Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car. _____
Year & Model of other car. _____
7. What was the approximate damage done to your car? \$ _____
8. Visibility at time of accident: poor fair good other: _____
9. Road conditions at time of accident: icy rainy wet clear dark other (describe): _____
10. Where was your car struck?



In your own words, please describe accident: _____

11. Type of Collision: Head-on Broad-side Front Impact Rear-end car in front Rear impact Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

13. Did you see the accident coming? yes no
14. Did you brace for impact? yes no
15. Were seatbelts worn? yes no
16. Were shoulder harnesses worn? yes no
17. Does your car have headrests? yes no
18. If yes, what was the position of those headrests compared to your head before the accident?
 Top of headrest even with **bottom** of head Top of headrest even with **top** of head
 Top of headrest even with **middle** of neck
19. Was your car braking? yes no
20. Was your car moving at the time of the accident? yes no
21. If yes, how fast would you estimate you were going? _____ mph
22. the other car? _____ mph
23. Head/Body position at the time of impact:
 Head turned left/right Head looking back Head straight forward
 Body straight in sitting position Body rotated right/left Other: _____
24. As a result of the accident you were:
 Rendered unconscious In shock Dazed, circumstances vague Other: _____
25. How was the shoulder harness adjusted? Loose Snug
26. Were you wearing a hat or glasses? yes no
27. Could you move all parts of your body? yes no
28. If no, what parts couldn't you move and why? _____
29. Were you able to get out of the car and walk unaided? Yes No
30. If no, why not? _____
31. Did you get any bleeding cuts? yes no If yes, where? _____
32. Did you get any bruises? yes no If yes, where? _____
33. Describe how you felt immediately after the accident: _____
Later that day: _____
The next day: _____

34. Check symptoms apparent since the accident:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Neck pain/Stiffness | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Anxious/Nervousness | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Breath shortness | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing/Buzzing | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Clicking / Popping Jaw | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Other _____ | | | |

35. Occupation: _____ 36. Employer: _____

37. Have you missed time from work: yes no

38. If yes, full time off work: _____ to _____

39. If yes, part time off work: _____ to _____

40. Did you seek medical help immediately after the accident? yes no

41. If yes, how did you get there? Ambulance Police Someone drove me Drove myself Other: _____

42. Doctor #1: Name: _____ 43. First Visit Date: _____

44. Were you examined? yes no 45. Were X-rays taken? yes no

46. Did you receive treatment? yes no Medications Braces Collars

47. If yes, what kind of treatment did you receive? _____

48. What benefits did you receive from the treatment? _____

49. Date of last treatment? _____

50. Doctor #2: Name: _____ 51. First Visit Date: _____

52. Were you examined? yes no 53. Were X-rays taken? yes no

54. Did you receive treatment? yes no Medications Braces Collars

55. If yes, what kind of treatment did you receive? _____

56. What benefits did you receive from the treatment? _____

57. Date of last treatment: _____

58. Do you have an attorney on this claim? yes no

59. If yes, who? _____

Address _____

City _____ State _____ Zip _____ Phone _____

Illustrate how the accident happened.

PAST MEDICAL HISTORY: Place an (X) if it applies and describe.

- None related to current complaints Hospital or operation Auto Accident Work Accident Illness Other

Describe _____

FAMILY HISTORY: Place an (X) if any family member has suffered from:

- | | | | | |
|---------------------------------------|---|--|---|---------------------------------------|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Spinal Disorder | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Allergy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other, list: _____ | |

PERSONAL HISTORY: Place an (X) if it applies, describe.

- Single Married Divorced Separated Widow/Widower Employed Spouse? yes no
- Number of Children _____ Number of Children at home _____ Are you pregnant? yes no not sure
- Medications, describe _____
- _____
- Disease, describe _____
- _____
- Other, describe _____

SYSTEM REVIEW Place an (X) next to the symptoms you know you have

GENITO-URINARY SYSTEM

- Bladder trouble Excessive urination Scanty urination Painful urination Discolored urine

GASTRO-INTESTINAL SYSTEM

- Poor appetite Excessive hunger Difficult chewing Difficult swallowing Excessive thirst Nausea
- Vomiting food Abdominal pain Diarrhea Constipation Black stool Bloody stool
- Hemorrhoids Liver trouble Weight trouble Gall bladder trouble

NERVOUS SYSTEM

- Numbness Loss of feeling Paralysis Dizziness Fainting Headaches
- Muscle jerking Convulsions Forgetfulness Confusion Depression

CARDIO-VASCULAR SYSTEM

- Chest pain Pain over heart Difficult breathing Persistent cough Coughing blood Coughing phlegm
- Rapid heartbeat High blood pressure Heart problems Lung problems Varicose veins Other

EYES, EARS, NOSE AND THROAT SYSTEM

- Eye strain Eye inflammation Vision problems Ear pain Ear noises Ear discharge
- Hearing loss Breathing Difficulty Nose bleeding Nose discharge Sore gums Nose Pain
- Sore mouth Sore throat Hoarseness Speech difficulty Dental problems

ACTIVITIES OF DAILY LIVING ASSESSMENT

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

SECTION 1: PAIN INTENSITY

- | | |
|---|--|
| <input type="checkbox"/> I can tolerate the pain I have without using pain killers. | <input type="checkbox"/> Pain killers give moderate relief from pain. |
| <input type="checkbox"/> The pain is bad but I manage without taking pain killers. | <input type="checkbox"/> Pain killers give very little relief from pain. |
| <input type="checkbox"/> Pain killers give complete relief from pain. | <input type="checkbox"/> Pain killers give no relief from pain. I do not use them. |

SECTION 2 : PERSONAL CARE

- | | |
|--|---|
| <input type="checkbox"/> I can look after myself normally without causing extra pain. | <input type="checkbox"/> I need some help but manage most of my personal care. |
| <input type="checkbox"/> I can look after myself normally but it causes extra pain. | <input type="checkbox"/> I need help every day in the most aspects of self care. |
| <input type="checkbox"/> It is painful to look after myself and I am slow and careful. | <input type="checkbox"/> I do not get dressed, wash with difficulty, and stay in bed. |

SECTION 3: LIFTING

- | | |
|--|---|
| <input type="checkbox"/> I can lift heavy weights without extra pain. | <input type="checkbox"/> Pain prevents me from lifting heavy weights. I can manage light to medium weights if they are conveniently positioned. |
| <input type="checkbox"/> I can lift heavy weights but it causes extra pain. | <input type="checkbox"/> I can lift only very light weights. |
| <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table). | <input type="checkbox"/> I cannot lift or carry anything at all. |

SECTION 4: WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk using a cane or crutches.
- I am in bed most of the time and have to crawl to the toilet.

SECTION 5: SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than one hour.
- Pain prevents me from sitting for more than 30 minutes.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6: STANDING

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it causes extra pain.
- Pain prevents me from standing for more than one hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7: SLEEPING

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

SECTION 8: SEX LIFE

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

SECTION 9: SOCIAL LIFE

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 10: TRAVELING

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to the journeys of less than one hour.
- Pain restricts me to short necessary trips under a 1/2 hour.
- Pain restricts me from traveling except to the doctor or hospital.

CURRENT CHIEF COMPLAINTS:

Place an (X) in the appropriate complaint areas.

SPINE

- Low back
- Mid back
- Neck
- Pelvis

UPPER EXTREMITY

- Shoulder R/L
- Arm R/L
- Elbow R/L
- Wrist R/L
- Forearm R/L
- Hand R/L

LOWER EXTREMITY

- Hip R/L
- Thigh R/L
- Knee R/L
- Leg R/L
- Ankle R/L
- Foot R/L

OTHER (describe): _____

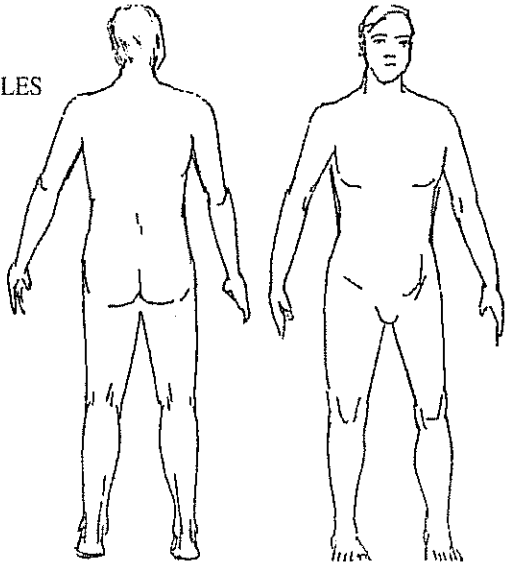
SUBJECTIVE PAIN LEVEL:

On a scale of 1 - 10, place an (X) in your current pain level

- NORMAL** **EMERGENCY**
- 1
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7
 - 8
 - 9
 - 10

Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

- × NUMBNESS
- + BURNING
- PIN & NEEDLES
- = STABBING



Patient's Signature _____