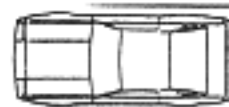


Account#: _____

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 the 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? FRONT REAR



11. Type of Accident: Head-on collision Broad-side collision Front Impact
 Rear-end car in front 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. How fast would you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
 Head turned left/right Body straight in sitting position
 Head looking back Body rotated right/left
 Head straight forward 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
Did they fly off your head? 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. Please describe how you felt immediately after the accident: _____

Later that day: _____

The next day: _____

34. Have you missed time from work: Yes No
35. If yes, full time from work: _____ to _____
36. If yes, part-time off work: _____ to _____
37. Did you seek medical help immediately after the accident? Yes No
Were you hospitalized? Yes No
38. If yes, how did you get there? _____ Ambulance _____ Police
_____ Someone else drove me _____ Drove own car _____ Other: _____

39. Doctor Name: _____ D.C./ M.D./ Emergency Rm.

What City: _____

40. First Visit Date: _____

41. Were you examined? Yes No
42. Did you receive treatment? Yes No ___ Medications ___ Braces ___ Collars
43. If yes, What kind of treatment did you receive? _____
44. What benefits did you receive from the treatment? _____
45. PLEASE EXPLAIN IN DETAIL 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 you or any family member has suffered from:

___ Tuberculosis ___ Kidney Disease ___ Spinal Disorder
___ Mental Illness ___ Epilepsy ___ Diabetes
___ Gout ___ Allergy ___ Arthritis
___ Hypertension ___ Cancer ___ Migraines
___ Heart Attack ___ Other, list: _____