CENTER FOR HEALTH
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AUTO ACCIDENT/PERSONAL INJURY QUESTIONNAIRE

Name:_____ Today's Date: _____
Address:_____
Phone: Home:_____Cell:_____Work:_____Email:_____
Social Security #:_____Sex: ☐M ☐F Date of Birth:_____Marital Status: _____
Occupation:_____

Date and Time of Accident_____AM ☐ PM

Did the police come to the accident site? ☐Yes ☐No
Was a police report filed? ☐Yes ☐No
Were there any witnesses? ☐Yes ☐No

What was your position in the car?
☐Driver: If Driver were your hands on the steering wheel? ☐Left ☐Right ☐Both
☐Passenger: If passenger, were you sitting in ☐Front ☐Right Rear ☐Left Rear

Did you brace for impact? ☐ Yes ☐No ☐I braced with my hands ☐I braced with my feet
Which way were you facing at the time of impact? ☐Straight ahead ☐Left ☐Right
Did your vehicle strike another vehicle? ☐Yes ☐No Was your vehicle struck by another vehicle ☐Yes ☐ No
Number of people in the accident vehicle? _____
Were you wearing a seat belt? ☐Yes ☐No
Was this vehicle equipped with air bags? ☐Yes ☐No
If yes, did it/they inflate? ☐Yes ☐No
In relation to the base of your skull where was the headrest? ☐Above ☐Below ☐At base of skull
What did your vehicle impact? ☐Another vehicle ☐Other_____
Did you strike anything in vehicle at time of impact? ☐Yes ☐No
If yes, specify what part of your body struck what? _____
Did the seat back bend / break? ☐Yes ☐No

Where did accident happen? Describe the accident in your own words:

Make and model of vehicle you were occupying? _____
Make and model of other vehicle? _____
Name and location of street you were traveling? _____
What direction were you headed? ☐N ☐S ☐E ☐W ☐ ☐
What was the approximate speed of your vehicle?_____What was approximate speed of other vehicle?_____
Did the impact to your vehicle come from the ☐Front ☐Rear ☐Right Side ☐Left Side ☐Other_____
During impact were you facing ☐Right ☐Left ☐Forward

Immediately following the accident, how did you feel? ☐dizzy/dazed ☐disoriented ☐unconscious-how long?_____
☐nervous ☐nauseous ☐upset ☐weak ☐Other_____
Did you go to hospital ☐Yes ☐No Were you admitted to the hospital? ☐Yes ☐No If yes, how long? _____
If you went to hospital, when? ☐At time of accident ☐Next day ☐Two days plus
How did you get to hospital? ☐Ambulance ☐Police Car ☐Private Transportation
Name of Hospital: _____
Attended by Dr. _____
If so, what treatment was given? _____
Have you seen any other doctor as a result of this accident? ☐Yes ☐No If yes, when? _____
Doctor's name: _____

Chief Complaints or Symptoms as a result of this accident. Mark all that apply.

☐**Neck pain**	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand
If it radiates, mark where it goes	☐right shoulder ☐right arm ☐right forearm ☐right hand

☐Jaw Pain ☐Rt ☐Lt	☐Headache	☐Blurry Vision	☐Ringing in Ears
☐Shoulder Pain ☐Rt ☐Lt	☐Dizziness	☐Nervousness	☐Loss of Concentration
☐Chest Pain	☐Fatigue	☐Anxiety	☐Depression
☐**Upper back pain** ☐Rt ☐Lt	☐Difficulty with sleeping at night		☐Fear of driving in a car

☐**Low Back Pain**	☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee
select the areas of radiation, if any...	☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Additional Symptoms/ Complaints:

Is your condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful		Comfortable	Uncomfortable	Painful
Standing				Walking			
Sitting				Running			
Lying Down				Working			
Lovemaking				Lifting/Bending			

Have you lost any time from work due to your injuries? ☐No ☐Yes, give dates:_____
Type of employment:_____
How many hours are in your normal workday? _____

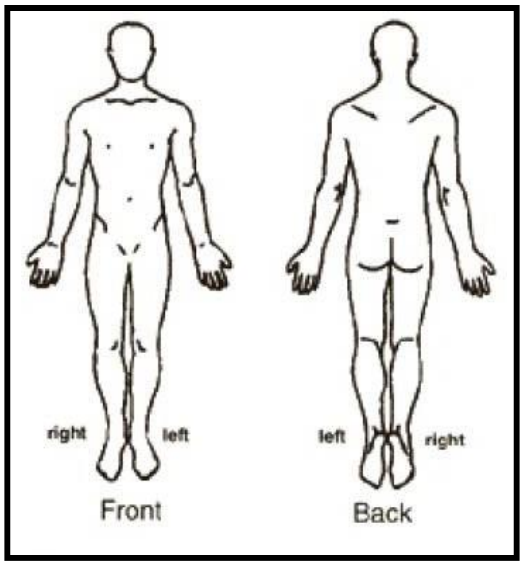
Please indicate your daily job duties and any activities you are occasionally asked to perform.

☐Standing ☐Driving ☐Operating Equipment ☐Bending ☐Stooping ☐Work with arms above head
☐Sitting ☐Twisting ☐Walking ☐Crawling ☐Typing ☐Lifting ☐Other_____

Prior to the accident were you capable of working on an equal basis with others? ☐Yes ☐No ☐N/A
While in recovery is there any light duty work you can request? ☐Yes ☐No ☐N/A

Have you retained an attorney? ☐Yes ☐No If yes, whom? _____

Please mark on the pictogram with an X the site(s) where your pain is.



Overall Pain Scale

Please circle the number that best describes your pain. If multiple areas, please put numbers on the above chart.

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Please Sign:_____ Date: _____