AUTO ACCIDENT HISTORY

Name:_____ Date:_____ _____

Describe the collision in your own words: _____

_____

_____

_____

What was your position in car? DRIVER PASSENGER If passenger, were you sitting in the FRONT RIGHT/LEFT REAR

Did your vehicle strike other vehicle? YES NO Was your car struck by other vehicle? YES NO

Was impact from FRONT RIGHT SIDE LEFT SIDE REAR Was your car pushed FORWORD or SIDEWAYS?

If yes, how much: LESS THAN 1/2 CAR LENGTH 1/2 CAR LENGTH ONE CAR LENGTH MORE THAN ONE CAR LENGTH

At the time of impact were you: LOOKING STRAIGHT AHEAD LOOKING RIGHT LOOKING LEFT

Was the trunk of your body pointed forward? YES NO If no, what direction was it turned? LEFT RIGHT REAR

If you were the driver, were both hands on the steering wheel? YES NO If not, where: _____

Was your foot on the brake? YES NO If you were a passenger, was the driver's foot on the brake? YES NO UNKNOWN

Were you aware or surprised for the impact? AWARE SURPRISED Where in the car were you after the accident? _____

Were you wearing seat belts? YES NO If yes, was it... LAP BELT ONLY or SHOULDER and LAP BELT

Did you receive any injury or bruise from the seat belt (i.e. breast or abdomen)? YES NO

If yes, please describe: _____

Does your vehicle have an air bag? YES NO If yes, did the air bag deploy? YES NO

Did you receive an injury from the air bag? YES NO Please describe: _____

Did you strike anything in the vehicle at the time of impact? YES NO

On what part of the automobile did your following parts hit?

Head:_____ Chest: _____

Right/Left Shoulder: _____ Right/Left Arm: _____

Right/Left Hip: _____ Other _____

Did things fly around in the car upon impact (i.e. ashtray, glove box opened, mirror flew off…) _____

What is the approximate distance between the back of your head and your seat's headrest? _____ inches

How far is the headrest from the top of your head? Approximately _____inches above, _____ inches below or EVEN

Number of other people in the vehicle you were in? _____

The road surface at the time of the accident: WET DRY ICY PAVEMENT GRAVEL DIRT OTHER _____

What is the year: _____, make: _____, and model: _____ of the car you were in?

Was your car stopped at the time of impact? YES NO If no, then estimate the speed of the vehicle you were in: _____mph

Was the vehicle you were in... SLOWING DOWN GAINING SPEED or traveling at a STEADY RATE of speed

What was the estimated cost damage to the vehicle you were in? $_____

Which of the following car parts broke during the accident? WINDSHIELD FRONT SEAT STEERING WHEEL

RIGHT/LEFT SIDE WINDOW REAR WINDOW OTHER: _____

What is the year: _____, make:_____, and model: _____ of the other vehicle?

Was the other vehicle a SMALLER LARGER or SIMILAR sized car?

The other vehicle was TOTALED or had MAJOR DAMAGE MINOR DAMAGE SOME BROKEN PARTS (list):_____

(Broken Parts Con't)_____

AUTO ACCIDENT HISTORY

Was the other vehicle SLOWING DOWN GAINING SPEED or traveling at a STEADY RATE at the time of impact?

The approximate speed of the other vehicle was _____mph

The posted speed limit was _____mph or UNKNOWN

Did the police come to the accident scene? YES NO Was an accident report filled out? YES NO

Were you checked at the scene for injuries by FIREMAN PARAMEDICS POLICE NO ONE

Did you go to the hospital? YES NO If yes, who took you? SELF PARAMEDICS SOMEONE ELSE (name): _____ N/A

Did you go to the hospital RIGHT AWAY LATER IN DAY THE NEXT DAY OTHER: _____ N/A

Did the paramedics place you in a: NECK BRACE SPLINT/BRACE STRAIGHT BOARD OTHER: _____ N/A

The name of the hospital: _____ in (city) _____How long did you stay? _____ N/A

What parts of you body were x-rayed at the hospital? _____ NONE N/A

Did they tell you what was wrong (give you a diagnosis) _____ N/A

Did they give you prescription medication? YES NO. If yes, list:_____ N/A

What else did the hospital do for your injuries? _____ NOTHING N/A

Attended by doctor: _____, who recommended I see: my OWN DOCTOR ORTHOPEDIST NEUROLOGIST

PHYSICAL THERAPIST OTHER _____ N/A

Who else have you seen as a result of this accident? _____

_____

When did you see them? _____

What was their treatment or recommendations? _____ Has it helped? YES NO

What bleeding cuts did you sustain during this accident?_____ NONE

What bruises did you sustain during this accident? _____ NONE

Did you lose consciousness (black out) upon impact? YES NO How long? _____

Do you remember the actual collision? YES NO Did you experience a flash of light or explosion in your head? YES NO

Did you become CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED BLURRED VISION

RING/BUZZ IN EARS from the accident?

Immediately following the accident how, or what, else did you feel? _____

_____

What other symptoms did you notice over the next 3-5 days? _____

_____

CURRENT STATUS

Are you **currently** suffering from any of the following (please mark): <u>You can skip this part if your accident was within the past two weeks</u>

- ☐ HEADACHES
- ☐ NECK PAIN
- ☐ NECK STIFF
- ☐ UPPER BACK PAIN
- ☐ MID BACK PAIN
- ☐ LOWER BACK PAIN
- ☐ ABDOMINAL PAIN
- ☐ NERVOUSNESS
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ CHEST PAIN
- ☐ DIZZINESS
- ☐ HEAD SEEMS TOO HEAVY
- ☐ SHORTNESS OF BREATH
- ☐ FATIGUE
- ☐ DEPRESSION
- ☐ LIGHT BOTHER EYES
- ☐ DIFFICULTY W/ MEMORY
- ☐ CAN'T CONCENTRATE
- ☐ FORGETFULNESS
- ☐ EARS RING OR BUZZ
- ☐ FACE FLUSHED
- ☐ LOSS OF BALANCE
- ☐ FAINTING SPELLS
- ☐ LOSS OF SMELL
- ☐ LOSS OF TASTE
- ☐ DIARRHEA
- ☐ COLD FEET
- ☐ COLD HANDS
- ☐ UPSET STOMACH/NAUSEA
- ☐ CONSTIPATION
- ☐ COLD SWEATS
- ☐ FEVER
- ☐ HEAT INTOLERANCE
- ☐ SLEEPING PROBLEMS
- ☐ ALCOHOL INTOLERANCE
- ☐ CONFUSED
- ☐ LIGHT HEADED
- ☐ BLURRED VISION
- ☐ DISORIENTED
- ☐ _____
- ☐ _____
- ☐ _____

AUTO ACCIDENT HISTORY

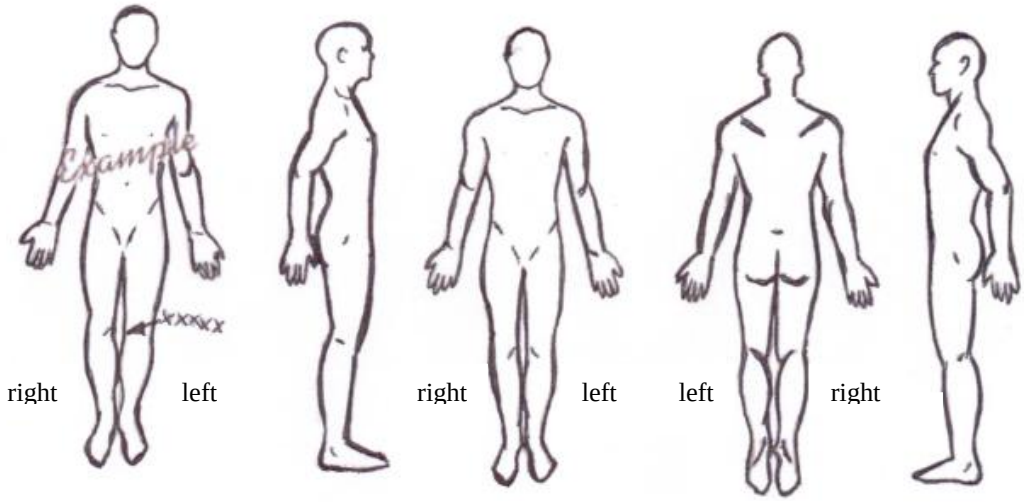
Do you have areas of numbness or tingling? RIGHT/LEFT ARM RIGHT/LEFT HAND RIGHT/LEFT FINGERS (1-2-3-4-5)
RIGHT/LEFT LEG RIGHT/LEFT FOOT RIGHT/LEFT TOES (1-2-3-4-5) FACE OTHER: _____

Do any of the following ache or hurt? RIGHT/LEFT SHOULDER RIGHT/LEFT ELBOW RIGHT/LEFT WRIST
RIGHT/LEFT HIP JOINT RIGHT/LEFT KNEE RIGHT/LEFT ANKLE

Do you have cramps in your... LEGS FEET ARMS ABDOMEN Have you had any changes in your bowel habits? YES NO

PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT USING THE FOLLOWING CODE:

Numbness	Pins and Needles	Burning	Aching	Stabbing	Throbbing	Intense pain
NNNN	**OOOO**	**XXXX**	++++	/ / / /	####	>>>>



EXAMPLE RIGHT FRONT BACK LEFT

INDICATE THE DEGREE OF PAIN USING A SCALE OF 1 (MILD DISCOMFORT) TO 10 (EXTREME PAIN) FOR EACH AREA
THEN LABLE EACH AREA OR REGION IN ORDER OF IMPORTANCE OR SEVERITY TO YOU (A, B, C, ETC)

Current symptoms other than above: _____

_____

_____

What is your overall sense of the pain (for the primary area or major complaint) MILD NUISANCE MILD TO MODERATE, BUT I CAN LIVE W/ IT
MODERATE, HAVING TROUBLE DEALING WITH IT SEVERE, IT IS RUINING MY QUALITY OF LIFE

Is your pain constant (primary complaint area?) YES NO Is your pain off and on? YES NO

How many days per week does this condition(s) bother you? _____ How many hours per day? _____

Is the primary complaint pain SHARP or DULL? Describe other characteristics of your pain: _____

_____

_____

_____

Is your pain worse when arising from a chair? YES NO Is it made worse by straining? YES NO By coughing? YES NO
By sneezing? YES NO By straining when moving your bowels? YES NO

AUTO ACCIDENT HISTORY

Is your pain worse with prolonged: SITTING STANDING DRIVING WALKING SLEEPING OTHER: _____

Do any of these activities worsen the pain? STRETCHING REACHING LIFTING BENDING TWISTING/TURNING SEX MOVING CHANGING POSITIONS LOOKING UP LOOKING DOWN OTHER: _____

What is your most comfortable position? SITTING STANDING LYING ON RIGHT/LEFT SIDE LYING ON BACK /STOMACH

Do you feel better MOVING AROUND RESTING Do you feel better in the: MORNING EVENING NO CHANGE DURING DAY

Do any of the following relieve your pain? HEATING PAD ICE HOT BATH SHOWER STRETCHES MASSAGE ALCOHOL OTHER (what do you do to relieve the pain?): _____

If you are taking any over the counter medication for these injuries, list what kind, how much, and how often: _____

_____

If you are using a brace or support does it help relieve the pain? YES NO What type of support do you use? _____

Does a change in heel height worsen the pain? YES NO Do you have normal sexual function? YES NO UNCERTAIN

Are you able to take care of your personal self such as dressing, bathing, etc.? YES NO

How is the pain compared to when it first started: MUCH IMPROVED SOMEWHAT IMPROVED NO CHANGE A LITTLE WORSE MUCH WORSE

How often do you have to stop what you are doing to sit, lay down, stretch, etc. to control the symptoms? CONSTANTLY SEVERAL TIMES PER DAY OCCASIONALLY ONCE OR TWICE PER DAY I DON'T HAVE TO STOP

What other activities or hobbies (recreational, exercise, house or yard chores etc) did you do **before** the accident that you find difficult or can't do now because of your injuries: _____

_____

Do you currently do a routine stretch or exercise program? NO YES If yes, briefly describe what you do and how often: _____

_____

_____

OCCUPATIONAL HISTORY

Have you lost any time at work because of this accident? YES NO

If yes, give dates of time lost: From _____ to _____

What is your occupation? _____

Name of employer: _____ City you work in: _____

How many hours are in your normal work day (before accident)?_____ How many since? _____ SAME

I normally start work at _____am pm and get off work at _____ am pm

My commute time is usually _____min. on the way to work and _____ min. on the way home

AUTO ACCIDENT HISTORY

Please indicate your daily job duties, activities, and average hours you are asked to perform them:

- ☐ STANDING _____HRS
- ☐ SITTING _____HRS
- ☐ WALKING _____HRS
- ☐ LIFTING _____HRS
- ☐ DRIVING _____HRS
- ☐ TWISTING _____HRS
- ☐ CRAWLING _____HRS
- ☐ BENDING _____HRS
- ☐ OPERATING EQUIPMENT _____HRS
- ☐ WORK W/ ARMS OVER HEAD _____HRS
- ☐ TYPING _____HRS
- ☐ PHONE _____HRS
- ☐ OTHER:_____

_____

If necessary, what positions can you work in with minimal physical effort and for how long? _____

_____

_____

Prior to the accident were you capable or working on an equal basis with others your age? YES NO

Is your job physically stressful? YES NO Is your job mentally stressful? YES NO Is your work place noisy? YES NO

How satisfied are you with your job: VERY SOMEWHAT NEUTRAL NOT AT ALL NO COMMENT

Have you had to change jobs because of your injuries? YES NO If yes why? _____

If you continue to work, is it WITH or WITHOUT difficulty?

Describe what's difficult at work:_____

_____

Do you work with others who can help you with heavy lifting? YES NO

While in recovery, is there any light duty work you could request? YES NO

Are there any other comments regarding your injuries, the accident, or about your health you want the doctor to know about? _____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____