

ACCIDENT HISTORY
Questionnaire

PERSONAL INJURY PATIENT HISTORY

I. CLIENT PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____

City/State/Zip: _____ SS#: _____

Telephone: Home _____ Work _____ Message _____

Age: _____ Birthdate: _____ Place of Birth: _____

Education: _____

Highest grade: _____ Degrees: _____

II. THE ACCIDENT

1. Date of Accident: _____ 2. Time of Accident _____ a.m./p.m.

3. Location of Accident: _____

3a. Was the accident investigated? _____ If yes, name of law enforcement agency who investigated
the accident: _____ Accident Report # _____

4. Driver of Car _____

5. Address of Driver: _____

6. Insurance Name & Address: _____

7. Other Driver's Name: _____

8. Other Driver's Address: _____

9. Other Driver's Insurance: _____ Policy/Claim # _____

10. Address: _____

11. Adjuster's Name & Address: _____

12. Witness(es): _____

13. Address: _____

14. What witness will testify to? _____

15. Where were you seated? _____

16. Who owns the car? _____

17. Year & Model of car: _____

18. What was the approximate damage done to your car? _____

19. Visibility at time of accident: ___ Poor ___ Fair ___ Good ___ Other: _____

20. Road conditions at time of accident: ___ Icy ___ Rainy ___ Wet ___ Clear ___ Dark

___ Other (Describe): _____

21. Where was your car struck? ___ Right ___ Left ___ Rear ___ Front ___ Side

___ Other (Describe): _____

22. Type of accident: ___ Head-on Collision ___ Broadside Collision

___ Front Impact ___ Rear-end car in front ___ Non-collision

23. Describe in your own words what happened to you upon impact: _____

24. Were photographs taken? Yes No

If yes, who has photographs? _____

25. Did you give a statement? Yes No Written Tape Recorded

If yes, to whom?

Name: _____ Date of Statement _____

What was said? _____

Name: _____ Date of Statement _____

What was said? _____

26. Who has statement(s) now? _____

27. Did you see the accident coming? Yes No

28. Did you brace for impact? Yes No

29. Were seatbelts worn? Yes No

30. Were shoulder harnesses worn? Yes No

31. Does your car have headrests? Yes No

32. 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

33. Was your car braking? Yes No

34. Was your car moving at the time of the accident? Yes No

35. If yes, how fast would you estimate you were going? _____ mph

36. How fast would you estimate the other car was going? _____ mph

37. Head/Body position at the time of impact:

- | | |
|---|--|
| <input type="checkbox"/> Head turned left/right | <input type="checkbox"/> Body straight in sitting position |
| <input type="checkbox"/> Head looking back | <input type="checkbox"/> Body rotated right/left |
| <input type="checkbox"/> Head straight forward | <input type="checkbox"/> Other: _____ |

38. At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _____

39. As a result of the accident, were you

- Rendered unconscious dazed, circumstances vague other

40. Could you move all parts of your body? Yes No

41. If no, what parts couldn't you move and why? _____

42. Were you able to get out of the car and walk unaided? Yes No

43. If no, why not? _____

44. Did you receive bleeding cuts or bruises? Yes No

45. If yes, what bleeding cuts did you get from this accident? _____

46. If yes, what bruises did you get from this accident? _____

47. Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

48. Check symptoms apparent since the accident:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck pain/Stiffness | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Eyes light sensitive | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Breath shortness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing/Buzzing |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Tension | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Other: _____ | |

III. EMPLOYMENT

49. Job Duties: _____

50. Employer Name & Address: _____

51. Have you missed time from work? Yes No

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

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

54. Wages at time of accident:

\$ _____ Hourly rate

\$ _____ Monthly Income

\$ _____ Weekly Income

\$ _____ Commission Income

55. Date returned to work/medical restrictions: _____

56. Previous employers:

Name/Address: _____

Dates: _____ Job Title _____

Supervisor: _____ Rate of Pay: _____

Reason for leaving: _____

Name/Address: _____

Dates: _____ Job Title _____

Supervisor: _____ Rate of Pay: _____

Reason for leaving: _____

IV. MEDICAL TREATMENT

57. Did you seek medical help immediately after the accident? ____ Yes ____ No

If yes, how did you get there? ____ Ambulance ____ Police ____ Someone else drove me
____ Drove own car ____ Other: _____

58. Were you hospitalized? ____ Yes ____ No

If yes, name and address of hospital _____

PLEASE LIST ALL MEDICAL PROVIDERS (doctors, x-rays, physical therapy, etc. and attach copies of any bills or receipts, including prescriptions)

59. Doctor #1: Name & Address: _____

60. First Visit Date: _____

61. Were you examined? ____ Yes ____ No

62. Were x-rays taken? ____ Yes ____ No

63. Did you receive treatment? ____ Yes ____ No

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

65. What benefits did you receive from the treatment? _____
66. Date of last treatment: _____
67. Doctor #2: Name & Address: _____
68. First Visit Date: _____
69. Were you examined? Yes No
70. Were x-rays taken? Yes No
71. Did you receive treatment? Yes No
72. If yes, what kind of treatment did you receive? _____
73. What benefits did you receive from the treatment? _____
74. Date of last treatment: _____
75. Doctor #3: Name & Address: _____
76. First Visit Date: _____
77. Were you examined? Yes No
78. Were x-rays taken? Yes No
79. Did you receive treatment? Yes No
80. If yes, what kind of treatment did you receive? _____
81. What benefits did you receive from the treatment? _____
82. Date of last treatment: _____
83. Physical Therapist seen: _____
- Address: _____

(Please use separate sheet for additional doctors if needed)

90. Illustrate below how the accident happened:

Past medical history: Place an (X) if it applies and describe.

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

Describe: _____

Family History: Place an (X) if any family member has suffered from:

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

Personal History: Place an (X) if it applies, describe:

Single Married Divorced Separated Widow/Widower

Spouse's name: _____

Dependent _____ Age: _____

Dependent _____ Age: _____

84. Did you have an attorney on this claim? ____ Yes ____ No

85. If yes, who? _____

Address: _____

City _____ State _____ Zip _____ Phone _____

86. List the name and address of all medical practitioners who examined or treated you for any mental or physical condition during the past ten (10) years and the condition or complaint the examination or treatment was performed.

Doctor Name, Address & Phone Number

Condition Treated

Doctor Name, Address & Phone Number	Condition Treated
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

87. List any prior lawsuits: _____

88. List all prior accidents: _____

89. What are your present

Needs: _____

Fears: _____

Worries: _____

Congenitals, describe: _____

Medications, describe: _____

SYSTEM REVIEW

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 ___ Gall bladder trouble
___ Weight 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 phlegm ___ Coughing blood
___ Rapid heartbeat ___ High blood pressure ___ Heart problems
___ Lung problems ___ Varicose veins ___ Other

Eye, Ear, Nose, and Throat System

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

Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the attorney 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

- I can tolerate the pain I have without using pain killers.
- The pain is bad but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers give no relief from pain and I do not use them.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

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

SECTION 3 - LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only light weights.
- 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 of sleep.
- Even when I take tablets, I have less than 4 hours of sleep.
- Even when I take tablets, I have less than 2 hours of 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 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 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.

Chief Complaint(s)

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

____ 0

LOW PAIN

____ 1 ____ 2 ____ 3

MODERATE PAIN

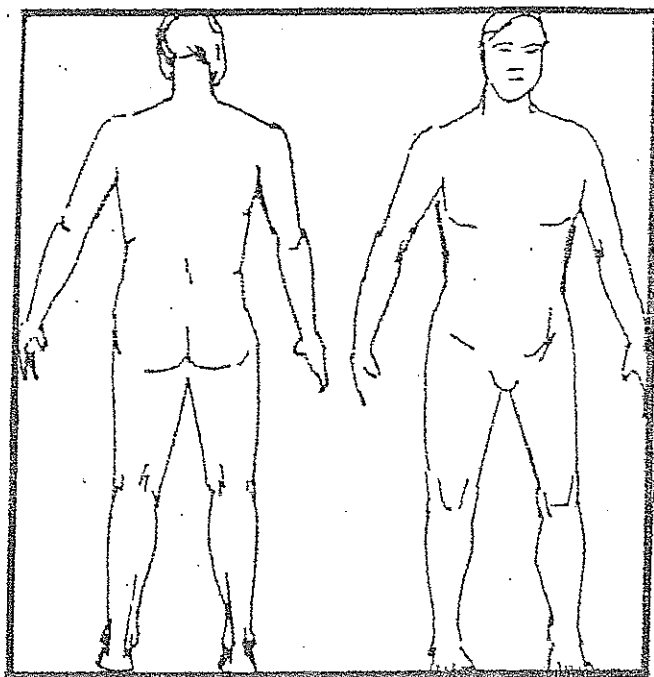
____ 4 ____ 5 ____ 6

INTENSE PAIN

____ 7 ____ 8 ____ 9

EMERGENCY

____ 10



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

X Numbness + Burning
o Pin & Needles = Stabbing

Client Signature