

General Information

Date of accident: _____

You were the: Driver Passenger

If passenger, you were seated:

In the front center
In the back left

In the front right
In the back center

In the back right

You were in a: Car Van Truck SUV Motor cycle.

The car you were in was: Compact Mid Size Full Size

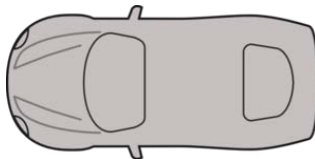
Was the vehicle: Stopped Slowing Acceleration ____mph Cruising ____mph

Time of accident: Day light Dawn Dusk Dark

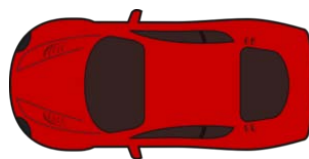
Road Condition: Dry Damp Wet Snow Ice

Visibility: Good Fair Poor

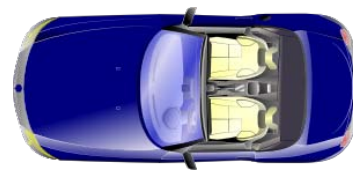
Impact Information (I): This box is related to the car you were in:



Other Driver



Your car



Other Driver

Please briefly describe what happened, and use the above images to illustrate with an X where your car was hit:

You impacted with?

The vehicle that hit you was a:

The size of the vehicle that hit you was:

Vehicle

Car Van

Subcompact

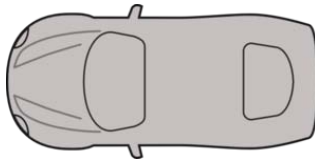
Object: _____

Truck Bus SUV

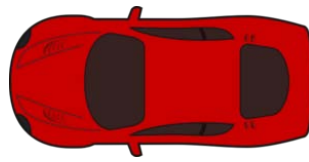
Compact Mid-size

Full-size

Impact Information (II) : This section is related to the other car that was involved.



Other Driver



Your car



Other Driver

Please briefly describe, and use the above images to illustrate with an X where the other vehicle suffered damages :

The other person's vehicle that hit you was a: Car Van Truck Bus SUV
 The size of the vehicle that hit you was: Subcompact Compact Mid-size Full-size

During Impact Information:

Seat Belt?	Yes	No				
Air Bag Deployed?	Yes	No				
Seat Broken?	Yes	No				
Brakes applied?	Yes	No				
Body Thrown:	Yes	No				
Seat Back position Changed?	Yes	No				
Head Rest:	Low	Mid	High	None		
Prepare for Accident:	Un-expected	Expected	Expected and Braced			
Body Position:	Straight	Rotated Left	Rotated Right	Unsure	Other:	
Direction of Throw:	Backwards	Forward	Outside	Unsure	Other:	

Body Impact (which parts of your body were struck during the impact)

Head	Upper Back	Right Hand	Lower Back
Left Shoulder	Left Leg	Mid Torso	Right Foot
Left Arm	Right Leg	Mid Back	Left Foot
Left Elbow	Right Shoulder	Right Knee	
Left Hand	Right Arm	Left Knee	
Upper Front Torso	Right Elbow	Lower Front Torso	

After Accident Information

Immediately After Accident you felt:	Dizzy/dazed	Upset	Weak	Nervous
	Disoriented	Unconscious		Headache

Pain (Indicate if you experienced any pain immediately following the accident)

Head	Left foot	Right foot	Left knee
Left Hand	Left Shoulder	Right Shoulder	Right knee
Right Arm	Left Elbow	Left Arm	Other:
Upper Front Torso	Mid Torso	Right elbow	
Upper Back	Mid back	Lower Front Torso	
Left Leg	Right Leg	Lower Back	

Numbness:	Left Hand	Right Hand	Left Leg	Right Leg	Left Upper Arm
	Right Upper Arm	Left Foot	Right Foot	Other:	

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	Yes	No
----------------------	-----	----

Time of Care?	Next Day	At the time of accident	Later that day	Days later	
Transported?	Drove self	Ambulance	Other		
Went to:	Orthopedic/Chiropractor	Neuro	Family Doc	ER	Other:___
Admitted to Hospital:	Yes	No	Days Spent in Hospital:		
Test:	X-rays	Lab work	MRI	CT Scan	Other:___
Treatment:	Ice Pack	Hot Pack	Cervical Collar	Medication	Other:___

Previous Injuries

Previous Injuries/ Accidents	No	Yes, specify:
------------------------------	----	---------------

Residual Pain from previous injuries/Accidents	No	Yes, specify:
--	----	---------------

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	Headache	Dizziness	Blurred Vision	Light Headedness	Loss of Vision
	Fainting	Loss of Memory	Pain in ear	Double vision	
	Other, specify:				

Neck (with movement)	Pain in neck	Forward	Backwards	Turn left	Popping in Neck
	Muscle Spasms	Turn Right	Bend left	Bend right	
	Other, specify:				

Shoulders	Pain in shoulder joint	Tension in shoulders	Muscle spasms in Shoulder
	Pain across shoulder	Can't raise arms above:	Shoulder level/ Overhead

Arms and Hands:	Pain in Fingers	Numbness in Left Arm	Hands Cold
	Pin & needles in hands	Numbness in Right Arm	Loss of Grip Strength
	Pin & needles in fingers	Swollen joints in Fingers	Other, specify:

Chest:	Chest pain	Pain Around Ribs	Shortness of Breath	Breast pain
	Other, specify:			

Abdomen:	Nervous Stomach	Nausea	Diarrhea	Gas	Constipation
-----------------	-----------------	--------	----------	-----	--------------

Mid back: Sharp Stabbing Mid pain back Pain from front to back Dull Ache
 Pain in Kidney Area Muscle Spasms Pain between shoulders
 Other, specify

Lower Back Pain: Low back pain is worse when:

Working	Lifting	Stooping	Standing	
Sitting	Bending	Coughing	Lying Down	Muscle Spasms

Other, specify: _____

Hips, Legs & Feet: Pain in Buttocks Pain and needles in Legs Pain down leg
 Pain in hip joints Feet feel cold Swollen Feet
 Numbness in Toes Numbness of leg Knee pain
 Leg cramps Cramps in Feet

Other, specify: _____

General Nervousness Fatigue Irritable Depressed
 General Feel Rundown Prostate pain/Swelling
 Difficulty Urinating Night Urination
 Cramping Irregularity

I have a loss of sleep: [_____] hrs per night.
 I have lost weight: [_____] lbs since accident.
 I have gained weight: [_____] lbs since accident.
 Other:

Signature: _____

Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

