Injury Questionnaire

Name: ______________________________Age______ Home Phone #: __________________ Work Phone #: ______________

Address: ____City: ____________________________ State ____Zip: _________

Occupation: ____# Hours/Week Currently Working:________________________

E-mail Address: ____Cell Phone #: ____________________________

ACCIDENT INFORMATION: Date of Injury:___________ Where (State/City):____________________________________

Time of Accident: _________am/pm Were any tickets issued and to whom? ☐ Yes ☐ No ______________________

Were you the: ☐ Driver ☐ Front Seat Passenger (Right) ☐ Back Seat LEFT Passenger ☐ Back Seat RIGHT Passenger

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Left Side ☐ Right Side

What was the approximate speed at the time of the impact? Your vehicle _______mph Other vehicle _______ mph

What was the weather at the time of the collision? ☐ Dry ☐ Wet ☐ Icy

Was your vehicle in ☐ Parked ☐ Moving ☐ Stopped with brakes applied

At the time of the impact were you: ☐Looking straight ahead ☐ Looking to the left ☐Looking to the right ☐Looking down ☐ Looking up

Were you wearing a seat belt? ☐ Yes ☐ No Did the seat belt break as a result of the impact? ☐ Yes ☐ No
Did the seat belt have a shoulder harness? ☐ Yes ☐ No If yes, did it contribute to the pain you are experiencing? ☐ Yes ☐No

Did your seat have a head restraint (headrest)? ☐ Yes ☐ No Did your head ride over the headrest? ☐ Yes ☐ No

Did the air bag deploy? ☐ Yes ☐ No

Were you braced for the impact (did you see if happening and braced for it)? ☐Yes ☐No

Did you hit anything inside the vehicle? ☐ Yes ☐ No Check one: ☐ Seatbelt Restraint ☐ Steering Wheel ☐Dashboard ☐ windshield ☐ side door ☐ side window ☐other: ____

Which part of your body? ☐Chest ☐Head ☐Chin ☐Face ☐R and/or L Knee ☐R and/or L shoulder ☐R and/or L Hand ☐Other: _____________________________

Did your vehicle strike the other vehicle or object? ☐ Yes ☐ No If yes, explain: _________________________________

How much damage was there to the outside of the vehicle? ☐None ☐Some ☐A lot ☐ Totaled

How much damage was there to the inside of the vehicle? ☐None ☐Some ☐A lot

Did you experience immediate pain? ☐ Yes ☐ No If yes, Where: ____

Immediately after the accident were you: ☐ Conscious ☐ Dazed ☐ Unconscious

Did the ambulance/paramedics arrive at the scene? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No Did you drive to the hospital? ☐ Yes ☐ No Which hospital? _______________ When? __________________________

Were xrays taken? ☐ Yes ☐ No MRI? ☐ Yes ☐ No CT? ☐ Yes ☐ No Did they prescribe medication? ☐ Yes ☐ No

Are you currently taking medication? ☐ Yes ☐ No If yes, please name all:____

Please describe the accident in your own words:
____

____
_

____
_

What type of work do you do? ______________________________ List job requirements: ________________________________

Have you lost any days of work from this injury? ☐ Yes ☐No If yes, give dates:____

LIST ALL COMPLAINT: ____

____

Date when symptoms first appeared: _____________________________ Have you had this condition before? ______________

Did it begin Gradual? ☐ Yes ☐ No Sudden? ☐ Yes ☐ No How long has it been going on? ________________________________

What makes symptoms increase? ___________________________________ What relieves symptoms? ___________________________

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing How much of your day is pain? ☐10% ☐25% ☐50% ☐100%

Pain Intensity (circle): NONE 0 1 2 3 4 5 6 7 8 9 10 SEVERE

Does pain radiate into your (circle): L R Shoulder/Arm/Hand L R Buttocks/Leg/Foot Does not radiate

SYMPTOMS: Please check if you have experienced any of the following since this accident.

☐ Low Back Pain ☐ Tension Across Top of Shoulders ☐ Tired/Fatigued
☐ Pain between Shoulder Blades ☐ Numbness/Tingling in Arms/Hands ☐ Difficulty Sleeping
☐ Neck Pain ☐ Numbness/Tingling in Legs/Feet ☐ Ringing in Ears
☐ Difficulty talking ☐ Dizziness ☐ Brain Fog
☐ Tension/Headaches ☐ Pain in the legs/feet/buttocks ☐ Nausea
☐ Changes in Vision ☐ Pain in the hand/arm/shoulders ☐ Vomiting
☐ Difficulty swallowing ☐ Difficulty with balance ☐ Other: _________________________

PREVIOUS ACCIDENT HISTORY: Have you ever been involved in another motor vehicle accident? ☐ Yes ☐ No

If yes, please describe and give dates:
____
____
____
_

INSURANCE/ATTORNEY INFORMATION

Do you have an attorney? ☐ Yes ☐No If yes:
Name: ____ Phone number:___________________________________

Personal Injury Insurance Company Name: _____________________________ Claim #: ________________________________
Adjustor's Name: ____________________________Adjustors Phone number: __________________________________

Do you have health insurance? ☐Yes ☐No
Health Insurance (Secondary Insurance) Name: _________________________________Member Id: _____________________
Phone #: ____________________Policy Holder Name: ____________________ Date of Birth: ___________________________

I certify that the above questions were answered accurately.
Print Name: ______________________________ Patient Signature: _____________________________Date: _________