

ACCIDENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name _____ Date _____
Address _____
City _____ State _____ Zip Code _____
DOB _____ Age _____ SS# _____ Marital Status _____
Sex ☐ Male ☐ Female How did you hear about the office? _____
Home Phone _____ Work Phone _____
Employer _____ Occupation _____
Have you missed any days at work? ☐ Yes ☐ No Dates Missed: _____
Date of Accident _____ Time of Accident _____ AM/PM
Please Describe the accident in your own words: _____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

ACCIDENT SITE

Road/Street Name _____
City/State _____
Driving Conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other _____
Visibility: ☐ Poor ☐ Fair ☐ Good ☐ Other _____
Was your vehicle moving? ☐ Yes ☐ No
Speed of your vehicle: _____ mph

YOUR VEHICLE

Make and model of your car: _____
Were you wearing a seatbelt? ☐ Yes ☐ No
Were shoulder harnesses worn? ☐ Yes ☐ No
Did the airbag inflate? ☐ Yes ☐ No
Did your seat have a headrest? ☐ Yes ☐ No
If yes, what was the position of the headrest?
☐ Top of headrest even with **bottom** of head
☐ Top of headrest even with **top** of head
☐ Top of headrest even with **middle** of neck

OTHER VEHICLE

Make and model other vehicle _____
Speed of other vehicle _____ mph

IMPACT

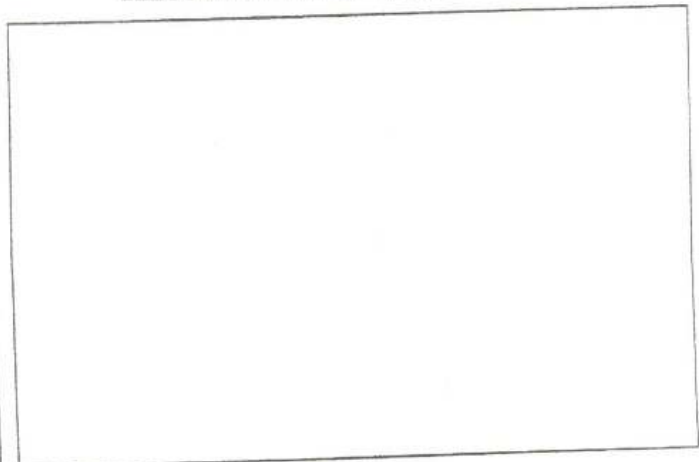
Did your car impact another vehicle? ☐ Yes ☐ No
Did your body strike anything inside the vehicle?
☐ No ☐ Yes, explain _____
Type of Impact: ☐ Front ☐ Rear ☐ Left
☐ Right ☐ Other _____

How were you sitting before impact?

☐ Head straight forward ☐ Body Straight
☐ Head up/down ☐ Body Rotated right/left
☐ Head turned right/left ☐ Other _____

Did you see the accident coming? ☐ Yes ☐ No
Did you brace for impact? ☐ Yes ☐ No
Was your car braking? ☐ Yes ☐ No

ILLUSTRATION OF THE ACCIDENT



PATIENT CONDITON

Were you unconscious after the accident? ☐ Yes ☐ No If yes, for how long? _____

Could you move all parts of your body? ☐ Yes ☐ No If no, which parts couldn't you move and why? _____

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No, why not? _____

Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____

Did you get any bruises? ☐ Yes ☐ No If yes, where? _____

Please describe how you felt, 1) immediately after the accident? _____

2) Later that day? _____

3) The next day? _____

TREATMENT

Did you go to the hospital immediately after the accident? ☐ Yes ☐ No

How did you get there? ☐ ambulance ☐ police ☐ someone else drove me ☐ drove own car

When did you go? ☐ Immediately after the accident ☐ Next day ☐ 2 days or more after the accident

Hospital Name: _____ Name of Doctor : _____

Treatment received: _____

Medications given: _____

X-rays taken: _____

Did you seek any additional treatment? ☐ Yes ☐ No If yes, who did you see? _____

Date of visit? _____ Treatment received: _____

SYMPTOMS

If you have had any of the following symptoms since the accident, please check off:

Rate each symptom with a number on a scale of 0-10 with 10 being the worst.

- | | | |
|---|--|--|
| ☐ Arm/Shoulder pain | ☐ Foot/toe numbness | ☐ Dizziness |
| ☐ Low back pain | ☐ Neck stiffness | ☐ Ear ringing |
| ☐ Neck pain | ☐ Headaches | ☐ Memory Loss |
| ☐ Upper back pain | ☐ Irritability | ☐ Jaw problems |
| ☐ Chest pain | ☐ Nausea | ☐ Sleep difficulty |
| ☐ Leg pain | ☐ Stomach upset | ☐ Blurred vision |
| ☐ Hand/finger numbness | ☐ Chest pain | ☐ Shortness of breath |

Past health history: Place an x if it applies and describe:

- | | | |
|---|--|----------------------------------|
| ☐ None related to current complaints | ☐ Hospitalized | ☐ Surgery |
| ☐ Other auto accident(s) | ☐ Work Accident | ☐ Illness |

Describe condition and treatment: _____

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"**Instructions: Please circle the correct response.****Historical Information**

- Have you ever been diagnosed or told you have any of the following?

- | | |
|--|--|
| 1. High Blood Pressure (hypertension) | ☐ Yes ☐ No |
| 2. Hardening of the arteries (arteriosclerosis) | ☐ Yes ☐ No |
| 3. Diabetes | ☐ Yes ☐ No |
| 4. Heart or blood vessel diseases | ☐ Yes ☐ No |
| 5. Bone spurs on the neck bones (cervical spondylosis) | ☐ Yes ☐ No |
| 6. Whiplash injury (flexion-extension injury) (cervical spine) | ☐ Yes ☐ No |
| 7. Have any of your relatives suffered a stroke? | ☐ Yes ☐ No |
| 8. Were you ever a smoker? If yes, from _____ to _____ | ☐ Yes ☐ No |
| 9. Do you take any medications on a regular basis? | ☐ Yes ☐ No |
| ▪ If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.) | |
| 10. (Women Only) Have you ever taken oral Contraceptives? | ☐ Yes ☐ No |
| ▪ If yes, from _____ to _____ | |

- Have you ever had any of the following, even short, temporary attacks, in the last year?

- | | |
|--|--|
| 1. Blurred Vision | ☐ Yes ☐ No |
| 2. Double Vision | ☐ Yes ☐ No |
| 3. Diminished or partial loss of vision in one or both eyes? | ☐ Yes ☐ No |
| 4. Complete loss of vision in one or both eyes? | ☐ Yes ☐ No |
| 5. Ringing, buzzing or any noise in the ear(s)? | ☐ Yes ☐ No |
| 6. Hearing loss in one or both ears? | ☐ Yes ☐ No |
| 7. Slurred speech or other speech problems? | ☐ Yes ☐ No |
| 8. Difficulty swallowing? | ☐ Yes ☐ No |
| 9. Dizziness? | ☐ Yes ☐ No |
| 10. Temporary lack of understanding? | ☐ Yes ☐ No |
| 11. Loss on consciousness, even momentary blackouts? | ☐ Yes ☐ No |
| 12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? | ☐ Yes ☐ No |
| 13. Any other abnormal sensations in any part of your body? | ☐ Yes ☐ No |
| 14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? | ☐ Yes ☐ No |
| 15. Sudden collapse without loss of consciousness? | ☐ Yes ☐ No |

Patient Signature _____ Date _____

Insurance Information

1. Your Auto Insurance:

- a. Name of Company _____
- b. Address _____
- c. Name of Insured _____
- d. Claim Number _____
- e. Adjuster's Name _____
- f. Adjuster's Direct phone number _____
- g. Adjuster's Fax number _____
- h. Do you have Medpay on your Auto Insurance Policy? _____
If yes what is the dollar amount? _____
- i. Claims mailing address: _____

2. Other Parties' Auto Insurance

- a. Name of Company _____
- b. Address _____
- c. Name of Insured _____

3. Do you have an attorney representing you on this claim? Yes _____ No _____

- a. Name _____
- b. Address _____
- c. Phone _____