Moon Chiropractic

Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of Accident: _____
2. Time: _____ AM/PM
3. Driver of Car: _____
4. Where were you seated: _____
5. Who owns the car?: _____
6. Year and model of your car: _____
   Year and model of other car: _____
7. What was the approximate damage done to your car? $_____
8. Visibility at time of accident: □Poor □Fair □Good □Other_____
9. Road conditions at time of accident: □Icy □Rainy □Wet □Clear □Dark
10. Where was your car struck?

In your own words, please describe accident: _____
_____
_____

11. Type of accident: □Head-on collision □Broad-side collision □Front Impact
    □Rear-end car in front □Rear impact □Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car_____
13. Did you see the accident coming? □Yes □No
14. Did you brace for impact? □Yes □No
15. Were seat belts being worn? □ Yes □No
16. Were shoulder harnesses worn? □ Yes □No
17. Does your car have head rests? □ Yes □No
18. If yes, what was the position of those head rests compared to your head before the accident?
    □ Top of head rest even with bottom of head
    □ Top of head rest even with top of head
    □ Top of head rest even with middle of neck
19. Was your car braking? □Yes □No
20. Was your car moving at the time of the accident: □Yes □No
21. If yes, how fast would you estimate you were going? _____mph
22. How fast would you estimate the other car was going? _____mph
23. Head/body position at time of impact:
    □Head turned left/right □Body straight in sitting position
    □Head looking back □Body rotated right/left
    □Head straight forward □Other: _____

24. As a result of the accident you were: □Rendered unconscious □In shock
□Dazed, circumstances vague □Other
25. How was the shoulder harness adjusted? □Loose □Snug
26. Were you wearing a hat or glasses? □Yes □No
27. Could you move all parts of your body? □Yes □No
28. If no, what parts couldn't you move and why? _____
29. Were you able to get out of your car and walk unaided? □Yes □No
30. If no, why not? _____

31. Did you get any bleeding cuts? □Yes □No If yes, where?_____
32. Did you get any bruises? □Yes □No If yes, where? _____
33. Please describe how you felt:
Immediately after the accident:_____
Later that day:_____
The next day:_____

34. Check symptoms apparent since the accident

□Headache	□Neck pain/stiffness	□Mid back pain
□Eyes light sensitive	□Pain behind Eyes	□Dizziness
□Fainting	□Sleeping problems	□Numbness in fingers
□Numbness in toes	□Loss or smell	□Loss of taste
□Loss of memory	□Fatigue	□Breath shortness
□Irritability	□Depression	□Ringing/Buzzing
□Loss of balance	□Tension	□Cold hands
□Cold feet	□Diarrhea	□Constipation
□Chest pain	□Nervousness	□Cold sweats
□Anxious	□Facial pain	□Clicking or Popping Jaw
□Low Back Pain	□Other_____	

_____

35. Occupation: _____
36. Employer: _____
37. Have you missed time from work? □Yes □No
38. If yes, full time off work: _____to_____
39. If yes, Part time off work: _____to_____
40. Did you seek medical help immediately after the accident? □Yes □No
41. If yes, how did you get there? □Ambulance □Police □Someone else drove me
□Other_____
42. Doctor #1: Name:_____
43. First visit date:_____
44. Were you examined?□Yes □No
45. Were X-rays taken? □Yes □No
46. Did you receive treatment? □Yes □No
47. If yes, what kind of treatment did you receive? _____
48. What benefits did you receive from treatment?_____
49. Date of last treatment? _____
50. Doctor #2: Name:_____
51. First visit date:_____
52. Were you examined?□Yes □No
53. Were X-rays taken? □Yes □No
54. Did you receive treatment? □Yes □No
55. If yes, what kind of treatment did you receive? _____
56. What benefits did you receive from treatment? _____