Patient Questionnaire – Auto-Accident

Patient Name: ____ Birthday: ___/___/___

Today's Date: ___/___/___ New Patient ☐ Yes ☐ No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ________ AM / PM

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: ______________________________ Stay Duration? ______________________________

Taken by ambulance? ☐ Yes ☐ No

Describe how the Accident took place: ____

____

____

____

Describe how you felt at the time of the accident: ____

____

Describe how you felt the next day: ____

____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Type of Impact: ☐ Rear end ☐ Front ☐ Side Impact ☐ Roll Over

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Wearing Seat belt? ☐ Yes ☐ No **Shoulder Harness:** ☐ Yes ☐ No

Is the car equipped with airbags? ☐ Yes ☐ No **Did they deploy?** ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No **Did you brace yourself for impact?** ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other ____________________

Did your body hit anything inside the car? ☐ Yes ☐ No **Body Part:** ______________________

What part of the car did your body hit? ______________________________

Head trauma? ☐ Yes ☐ No **Loss of Consciousness?** ☐ Yes ☐ No For how long? ______________________

Imaging taken? ☐ X-rays ☐ MRIs **Areas:** ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other Imaging ______________________________

Additional Information Related to the Condition:

Have you ever had the same or similar condition or symptoms previous to the accident? ☐ Yes ☐ No

When? ___/___/___

Describe: ____

____

Please indicated any other healthcare providers whom you have seen due to the accident:

Name	Type of Licensure	Phone Number
____________________	____________________	____________
____________________	____________________	____________

Do you have follow-up appointments? : ____

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Loss of strength - legs	☐ Burning muscle pain	☐ Difficulty swallowing	☐ Sharp/shooting pain	

Other ______________________________

Have you experienced changes to:

☐ Eyes (sight)	☐ Ears (hearing)	☐ Nose (smell)	☐ Mouth (taste)	☐ Bladder
☐ Bowels	☐ Sleep	☐ Emotion	☐ Appetite	

Please Explain: ____

Medical History:

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) ____ ___/___/___

2) ____ ___/___/___

3) ____ ___/___/___