



Patient Name: _____

Date of Injury: _____

Time of Injury: _____

Town or City and Street where Crash Occurred: _____

What was the estimated damage to your vehicle? _____

Did the police come to the accident scene and make a report?

Yes

No

Is an attorney representing you? Name / Address / Phone:

AUTO ACCIDENT DESCRIPTION:

Describe How the Crash Happened:

Collision description:

Check All That Apply to You:

In the accident you were the:

single car crash
rear end crash
head-on crash
Two vehicle crash
side crash (T-boned)
hit guard rail / tree
more than three vehicles
rollover
ran off road

driver
front passenger
rear passenger



Describe the vehicle you were in
Model, Year and Make:

Describe the other vehicle:
Model, Year and Make:

- Sub Compact Car
- Compact Car
- Mid-Sized Car
- Full-Sized Car
- Pickup Truck
- Larger Than 1 Ton Vehicle

- Sub Compact Car
- Compact Car
- Mid-Sized Car
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Estimated crash speeds

Estimate how fast your vehicle was moving at time of crash: _____

Estimate how fast the other vehicle was moving at time of crash: _____

At the time of impact **YOUR** vehicle was:

At the time of impact the **OTHER** vehicle was:

- slowing down
- stopped
- gaining speed
- moving at steady speed

- slowing down
- stopped
- gaining speed
- moving at steady speed

During and after the crash, Your Vehicle

- kept going straight, not hitting anything
- kept going straight, hitting car in front
- was hit by another vehicle
- spun around, not hitting anything
- spun around, hitting another car
- spun around, hitting object other than car

Describe yourself during the crash

(check only the areas that apply to you)

- you were unaware of the impending crash.
- You were aware of the impending crash and relaxed before the collision
- you were aware of the impending crash and braced yourself
- your body, torso, and head were facing straight ahead
- you had your head and /or torso turned at the time of collision -- turned to left -- turned to right (circle one)
- you are intoxicated (alcohol or drugs) at the time of crash
- you are wearing a seatbelt
- you are holding onto the steering wheel at the time of impact



Indicate if your body hit something or was hit by any of the following:

(please draw lines and match the left side to the right side)

- | | |
|----------|------------------|
| head | windshield |
| face | steering wheel |
| shoulder | side door |
| neck | dashboard |
| chest | car frame |
| hip | another occupant |
| knee | seat |
| foot | seat belt |

Check if any of the following vehicle parts broke, bent, or were damaged in your car:

- windshield
- steering wheel
- dash
- seat frame
- side /rear window
- mirror
- knee bolster
- other --
- other --

Yes / No questions:

YesNo

<input type="checkbox"/>	<input type="checkbox"/>
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Did any of the front or side structures, such as the side door, dashboard, or floor board of your car, dent inward during the crash?

<input type="checkbox"/>	<input type="checkbox"/>
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Did the side door touch your body during the crash? Was your hand (s) on the steering wheel or dash during the crash?

<input type="checkbox"/>	<input type="checkbox"/>
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Did your body slide under the seatbelt? Was the door (s) of your vehicle damaged to the point where you could not open the door?

Rear end collision only:

Answer this section only if you are hit from the rear.

Does your vehicle have:

- movable head restraints
- fixed, non-movable head restraints
- no head restraints

Please indicate how your head restraint was positioned at the time of the crash.a

- at the top of the back of your head
- midway height of the back to your head
- lower height at the back of your head
- located at the level of your neck
- located at the level of your shoulder blades (upper back) below neck

Estimate the distance between the back of your head and the front of the head restraint.

_____ inches



Yes No

<input type="checkbox"/>	<input type="checkbox"/>
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Did you go to the emergency department after the accident?

Name of Hospital: _____

Date: _____

Time: _____

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Did you go to the emergency department in an ambulance?

Did you or another person drive you to the emergency department?

myself another person

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Were you hospitalized or observed in the emergency department overnight?

Did the emergency room doctor take x-rays? Check which x-rays were taken:

- skull
- neck
- low back
- arm or leg

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Did the emergency room doctor give you pain medications?

Did the emergency room doctor give you muscle relaxants?

Did you have any abrasions, cuts or lacerations?

Did you require any stitches for cuts?

When did you first notice any pain after injury?

- Immediately
- _____ hours after injury
- _____ days after injury

If you did not see a doctor for the first time within the first week, indicate why (check all that apply)

- no pain was noticed
- work /home schedule conflicts
- no appointment time available
- no transportation

If you did not see a doctor for the first time within the first month after injury, indicate why (check all that apply)

- no pain was noticed
- work / home schedule conflicts
- no appointment time available
- no transportation
- I thought pain would go away
- I self treated with over-the-counter drugs
- I took hot showers, used ice, heat

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you been unable to work since injury?

Have you had to change your work duties since your injury?

Please list dates off work: _____ to _____



HEAD INJURY QUESTIONNAIRE (fill only if head injured in accident)

Check What Your Head Hit or What Hit Your Head:

<input type="checkbox"/>	No head injury
<input type="checkbox"/>	Windshield
<input type="checkbox"/>	Dashboard
<input type="checkbox"/>	Other passenger
<input type="checkbox"/>	Steering wheel
<input type="checkbox"/>	Sidecar window
<input type="checkbox"/>	Mirror
<input type="checkbox"/>	Other _____

What part of your head was hit?

<input type="checkbox"/>	Front
<input type="checkbox"/>	Left side
<input type="checkbox"/>	Top
<input type="checkbox"/>	Back
<input type="checkbox"/>	Right Side
<input type="checkbox"/>	Other: _____

Please circle appropriate answer

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Did you lose consciousness or blackout for any time (seconds or minutes) after your head injury? How long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you lost in the memory of events before the head injury?
<input type="checkbox"/>	<input type="checkbox"/>	Have you lost any memory or has your memory been different since the head injury?
<input type="checkbox"/>	<input type="checkbox"/>	Did you have a lump or bruise after the head injury? Where?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any head injuries in your past (include childhood)?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any x-rays taken?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a CAT scan or MRI scan taken of your head?

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SINCE YOUR NECK OR HEAD INJURY?

<input type="checkbox"/>	headaches	<input type="checkbox"/>	difficulty handling multiple tasks
<input type="checkbox"/>	loss of coordination	<input type="checkbox"/>	dizziness / lightheadedness
<input type="checkbox"/>	reduced drive / motivation	<input type="checkbox"/>	irritability
<input type="checkbox"/>	poor memory	<input type="checkbox"/>	personality change
<input type="checkbox"/>	difficulty finishing tasks	<input type="checkbox"/>	hand tremors
<input type="checkbox"/>	sleep disorders	<input type="checkbox"/>	ringing in the ears
<input type="checkbox"/>	abnormal levels of anxiety	<input type="checkbox"/>	less diplomatic than normal
<input type="checkbox"/>	reduced tolerance to alcohol	<input type="checkbox"/>	mood swings
<input type="checkbox"/>	more assertive	<input type="checkbox"/>	reduced attention span
<input type="checkbox"/>	forgetful	<input type="checkbox"/>	blackouts
<input type="checkbox"/>	anger outbursts	<input type="checkbox"/>	indifference to other people
<input type="checkbox"/>	depression	<input type="checkbox"/>	more shallow relationships
<input type="checkbox"/>	fatigue	<input type="checkbox"/>	difficulty with solving problems
<input type="checkbox"/>	absence of ability to anticipate	<input type="checkbox"/>	less mental stamina
<input type="checkbox"/>	inflexibility	<input type="checkbox"/>	performance inconsistencies
<input type="checkbox"/>	impaired sexual function	<input type="checkbox"/>	verbal learning problems
<input type="checkbox"/>	language difficulty	<input type="checkbox"/>	slower reaction times
<input type="checkbox"/>	impaired judgment		
<input type="checkbox"/>	need daytimer or reminder to remember home and / or work activity's		
<input type="checkbox"/>	blurry vision		
<input type="checkbox"/>	loss of balance		



If you have experienced any of the symptoms below, place a "X" in the box in front of the symptom and a checkmark in each of the boxes of the four categories to describe it. (may include more than one.)

	Felt Right After Injury	Felt 24-48 Hours Later	Have Symptoms Now	Had Similar Symptoms 1 to 3 Months Before This Injury
Example: <input checked="" type="checkbox"/> Headache	X	X	X	

<input type="checkbox"/>	Headache				
<input type="checkbox"/>	Dizziness				
<input type="checkbox"/>	Tinnitus (Ear Ringing)				
<input type="checkbox"/>	Blurry Vision				
<input type="checkbox"/>	Memory Problems				
<input type="checkbox"/>	Poor Concentration				
<input type="checkbox"/>	Irritability				
<input type="checkbox"/>	Balance Problems				
<input type="checkbox"/>	Loss of Coordination				
<input type="checkbox"/>	Sensitivity to Sound				
<input type="checkbox"/>	Sensitivity to Light				
<input type="checkbox"/>	Fatigue				
<input type="checkbox"/>	Anxiety				
<input type="checkbox"/>	Pain / Difficulty Swallowing				
<input type="checkbox"/>	Jaw Pain				
<input type="checkbox"/>	Neck Pain / Soreness				
<input type="checkbox"/>	Neck Stiffness				
<input type="checkbox"/>	Shoulder Pain / Stiffness				
<input type="checkbox"/>	Arm Pain / Tingling / Numbness				
<input type="checkbox"/>	Wrist / Hand / Finger Pain / Numbness				
<input type="checkbox"/>	Weakness in Arms / Legs				
<input type="checkbox"/>	Upper / Mid Back Pain				
<input type="checkbox"/>	Chest Wall Pain (Rib)				
<input type="checkbox"/>	Low Back Pain / Soreness				
<input type="checkbox"/>	Hip Pain				
<input type="checkbox"/>	Leg Pain				
<input type="checkbox"/>	Leg Numbness / Tingling				
<input type="checkbox"/>	Pain Shoots down Legs				
<input type="checkbox"/>	Knee Pain				
<input type="checkbox"/>	Ankle / Foot Pain				
<input type="checkbox"/>	Other				



Have you experienced any of the following since your motor vehicle accident?

- | | | | |
|--------------------------|---|--------------------------|------------------------------------|
| <input type="checkbox"/> | headaches | <input type="checkbox"/> | difficulty handling multiple tasks |
| <input type="checkbox"/> | loss of coordination | <input type="checkbox"/> | dizziness / lightheadedness |
| <input type="checkbox"/> | reduced drive / motivation | <input type="checkbox"/> | irritability |
| <input type="checkbox"/> | poor memory | <input type="checkbox"/> | personality change |
| <input type="checkbox"/> | difficulty finishing tasks | <input type="checkbox"/> | hand tremors |
| <input type="checkbox"/> | sleep disorders | <input type="checkbox"/> | ringing in the ears |
| <input type="checkbox"/> | abnormal levels of anxiety | <input type="checkbox"/> | less diplomatic than normal |
| <input type="checkbox"/> | reduced tolerance to alcohol | <input type="checkbox"/> | mood swings |
| <input type="checkbox"/> | More assertive | <input type="checkbox"/> | reduced attention span |
| <input type="checkbox"/> | forgetful | <input type="checkbox"/> | blackouts |
| <input type="checkbox"/> | anger outbursts | <input type="checkbox"/> | indifference to other people |
| <input type="checkbox"/> | depression | <input type="checkbox"/> | more shallow relationships |
| <input type="checkbox"/> | fatigue | <input type="checkbox"/> | difficulty with solving problems |
| <input type="checkbox"/> | absence of ability to anticipate | <input type="checkbox"/> | less mental stamina |
| <input type="checkbox"/> | inflexibility | <input type="checkbox"/> | performance inconsistencies |
| <input type="checkbox"/> | impaired sexual function | <input type="checkbox"/> | verbal learning problems |
| <input type="checkbox"/> | language difficulty | <input type="checkbox"/> | slower reaction times |
| <input type="checkbox"/> | impaired judgment | | |
| <input type="checkbox"/> | need daytimer or reminder to remember home and / or work activities | | |
| <input type="checkbox"/> | blurry vision | | |
| <input type="checkbox"/> | loss of balance | | |



Prior Treatment Questions:

LIST THERAPISTS, TESTS AND TREATMENT SINCE INJURY:

Start with the first doctor, chiropractor or therapist / office / hospital you saw after injury and check all that apply:

1

2

Name of / Doctor / Therapist / Center:

Name of / Doctor / Therapist / Center:

Address: _____ Date: _____

Address: _____ Date: _____

Type of Therapy: (eg. physio, massage, chiro.)

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How many visits? _____

How many visits? _____

Indicate what was done:

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- Exam -- Consultation
- X-Ray of Neck
- X-Ray of Low Back
- Other X-Rays
- MRI / CAT Scan
- Other Diagnostic Test
- Rehabilitation
- Physical Therapy
- Exercise Recommended
- Medications Prescribed
- Neck Collar
- Spinal Manipulation / Adjustments
- Muscle Massage / Physiotherapy
- Low Back Brace
- Heat Packs Cold / Ice Packs
- Ultrasound
- Other

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- Low Back Brace
- Heat Packs Cold / Ice Packs
- Ultrasound
- Other

Indicate results of treatment and therapy:

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- helped but came back when I stopped treatment
- helped a bit and I kept my improvement
- didn't help at all
- made it worse

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Prior Treatment Questions:

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Name of / Doctor / Therapist / Center:

Address: _____ Date: _____

Type of Therapy: (eg. physio, massage, chiro.)

How many visits? _____

Indicate what was done:

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Prior Treatment Questions:

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Start with the first doctor, chiropractor or therapist / office / hospital you saw after injury and check all that apply:

5

6

Name of / Doctor / Therapist / Center:

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