ACCIDENT QUESTIONAIRE FORM

Patient Name:_____ Today's Date:____/_____/_____

Circle or Fill-in All That Apply

Date of Accident ___/____/____

You were the: Driver / Passenger ; Front seat, Rear Driver, Rear Passenger

Approx Time of Accident:____:____ am / pm

Weather conditions: (**circle all that apply**) dry rainy sunny foggy Cloudy

Seat belted : Y N

Did airbag deploy: Y N

Was the accident a **Surprise** or did you **Watch** it about to happen? S or W

Were you **Braced** at impact? Y N

Did you lose consciousness? Y N ; if yes, about how long? _____

Did you sustain any: Cuts / Lacerations / Bruises

If so, where?_____

Did you have immediate pain? Y N If so, Where?_____

Circle: Did any part of your body hit the interior of the car? *Head to headrest / *Head to glass / *Chest to steering wheel / *Knees to dashboard / *Hip to center console / *Other:_____

Did police come to the scene? Y N Was anyone ticketed? _____

Did Paramedics come? Y N ; If so, where you treated at the scene? Y N

Were you transported to a Hospital ER? Y N

If yes, what Hospital did you go to?_____

At the Hospital, what was done? Exam Treatment X-rays MRI CAT scan

Circle: What Rx prescriptions given at the hospital? *Pain Meds *Muscle relaxers *Anti-Inflammatory Other Rx _____

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DOB_____/____/_____

Ht: _____ft_____in

Wt:_____lbs.

Circle: You Are: Caucasian / African American / Hispanic / Asian / American Indian / Other_____

Married / Single / Divorced / Widowed / Widower /

Children Y N ; How many? _____

Current Rx Medications _____

Previous MVA's Y N ; If yes, list number and Year(s)_____

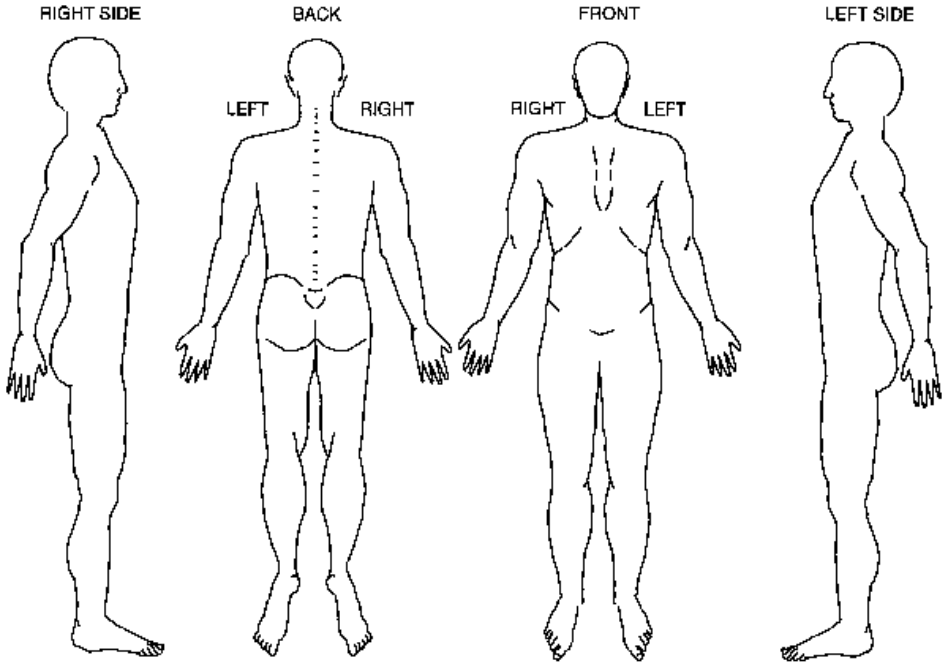
Current Employer: _____ Part time or Full Time

Job title & description: _____

Previous Hospitalizations Y N , if so explain_____

Previous Surgeries_____

Allergic to medications: Y N ; if so list _____ _____



Draw on diagram areas of Pain

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