ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____ Today's Date: _____

■ ACCIDENT INFORMATION

Date of Injury: _____

Please Describe how the accident occurred.

_____

_____

■ ACCIDENT INFORMATION

Where in the car were you at the time of the accident:

☐ *Driver Side* ☐ *Passenger Side* ☐ *Front Row* ☐ *Rear Row* ☐ *Pedestrian* ☐ *Other:* _____

Were you wearing seat belt*?* ☐ *Yes* ☐ *No* Did airbag deploy? ☐ *Yes* ☐ *No*

Where on your car was impacted? ☐ *Front* ☐ *Rear* ☐ *Passenger side* ☐ *Driver Side* ☐ *Other* _____

■ MEDICAL INFORMATION

At the time of the accident

Did you feel pain immediately after the accident? ☐ *Yes* ☐ *No*

If no, when? ☐ *Later that day* ☐ *Next day* ☐ *When?* _____

Did you go to a hospital or see any other doctor? ☐ *Yes* ☐ *No* ***How:*** ☐ *Ambulance* ☐ *Other:* _____

Did you suffer any cuts/bruises*?* ☐ *Yes* ☐ *No (Describe)* _____

Imaging taken*? (x-ray, CT, MRI)* ☐ *Yes* ☐ *No* *Region(s)* _____

_____

Fractures? ☐ *Yes* ☐ *No* *Region(s)/Location(s)* _____

Since the accident

Are your symptoms: ☐ *Getting Better* ☐ *Staying the same* ☐ *Getting worse*

Have you done anything to care for the symptoms? (i.e. ice, heat, rest avoid activities etc.)? ☐ *Yes* ☐ *No*

If yes – What? _____

Are you currently working? ☐ *Yes* ☐ *No* *Date last worked:* _____

Did you miss any work from the accident*?* ☐ *Yes* ☐ *No* *Dates:* _____

■ HEALTH STATUS BEFORE THE ACCIDENT

Were you capable of performing all your work activities without restriction? ☐ *Yes* ☐ *No*

If no – What were the restrictions? _____

_____

Have you ever had any complaints in the involved area before? ☐ *Yes* ☐ *No*

If yes – Were they present at the time of the incident/injury? ☐ *Yes* ☐ *No*

If yes - Summarize these complaints prior to the accident: _____

_____

_____