

Auto Accident Information

(To Be Completed by PI Patient)

Patient Name: _____

Date: _____

Date of Accident: _____

1. Tell me about your accident:

2. When did the accident happen? _____

3. Where did the accident happen? _____

4. How fast was the car going that hit you? _____

5. What kind of car hit you? _____

6. Where you or the other driver cited? _____

7. Were you in the car by yourself? _____

8. Did you have on your safety belt? _____

9. To the best of your knowledge, what happened to your body at the time of impact during the accident?

10. Did your head whip backward and forward forcefully? _____

11. Did you hear any popping, cracking, or snapping noises in your neck? _____

12. Did you have any immediate pain after the accident? _____

13. Did any part of your body (knees, arms, chest, head, etc) strike part of the car during the accident?

14. Do you or did you have any bruises? _____

15. Were you rendered unconscious? _____

16. Where you able to get out of the car under your own power or did you have to be assisted?

17. Were you taken to a hospital emergency room? If so, where? _____

18. Who took you to the hospital? _____

19. Were you examined at the hospital ER? _____

20. In your opinion, were you thoroughly examined? _____

21. Did you have x-rays taken? _____

22. What did they tell you about your x-rays? _____

23. When did you first begin to feel headaches? _____

24. Are the headaches mild, moderate or severe? _____

25. Are the headaches constant, daily or do they come and go? _____

26. Do you have pulsating, sharp pain or pressure? _____
27. Since the accident, have you had any dizzy spells? _____
28. Do you have any buzzing or ringing in the ears? _____
29. Do you have blurring of the eyes? _____
30. Does light bother your eyes? _____
31. Have you noticed any changes in your ability to remember, concentrate or think clearly since the accident?

32. Have you been more irritable? _____
33. Have you been more nervous? _____
34. Have you been depressed at all? _____
35. How have you been sleeping? _____
36. Tell me about your energy level. _____
37. Tell me about your neck pain. _____
38. Is your neck pain mild, moderate or severe? _____
39. Is your neck pain constant, daily or does it come and go? _____
40. Is your neck pain sharp, a dull ache or burning? _____
41. Have you noticed that you are restricted looking over your shoulder at times? _____
42. Do you have any pain that goes down your arms? _____
43. Do you have any numbness in your hands? _____
44. Do you have any upper back pain? _____
45. Is the pain mild, moderate or severe? _____
46. Is the pain constant, daily or does it come and go? _____
47. Is the pain sharp, a dull ache or burning? _____
48. Do you have any pain down your legs? _____
49. Do you have any abdominal pain? _____
50. Have you ever been in an auto accident before? _____
If yes, when? _____
51. Prior to this accident, did you ever have any headaches, neck pain, back pain, arm pain or leg pain?

52. How has this accident affected your work and home life?

