

OptimumHealth

An Integrative Approach To Healing

AUTO ACCIDENT / INJURY QUESTIONNAIRE

Name _____ Date _____

Date of Accident ____/____/____ Time of Accident _____ am pm

About the Accident:

Were you the: Driver Front Passenger Rear Passenger

Make and model of the vehicle you were occupying? _____

Total # of people in the vehicle: _____

Were the police notified? yes no

Was a police report filed? yes no

Were citations issued at the scene? yes no

Were there any witnesses? yes no

Were you wearing a seat belt? yes no If yes, lap/shoulder belt lap belt only

Was the vehicle equipped with airbags? yes no If yes, did they deploy? yes no

Did any part of your body strike anything inside the vehicle? yes no If yes, describe _____

What did your vehicle impact? another vehicle other _____

Name of the street/location on which you were traveling? _____

Direction you were traveling? N S E W

Approximate speed of your vehicle? _____ mph

If you were moving, were you: at a steady speed slowing down braking for the accident

Amount of traffic at the time of the accident? light moderate heavy

Weather conditions at time of accident? clear / dry wet / rainy overcast / dry

During the impact, which direction were you facing? Forward Right Left

What part of your vehicle was impacted? Right side Left side Front Rear Other

Were you aware or surprised by the impact? Aware Surprised

Make and model of other vehicle(s) involved? _____

Direction other vehicle(s) were traveling? N S E W

Approximate speed of other vehicle(s)? _____ mph

Briefly describe in your own words what happened: _____

After the accident

Did you lose consciousness after the impact? yes no If so, for how long? _____

Describe briefly how you felt after the accident: _____

Did you receive emergency care at the scene? yes no If yes, describe: _____

Where did you go immediately after the accident? home work emergency room other _____

Have you gone to the hospital or seen any other doctor? yes no

If yes, list name of hospitals and/or doctors along with dates:

Describe any treatment you have received: _____

Were X-rays taken? yes no

Was medication prescribed? yes no

Have you been able to work since this injury? yes no

Are your work activities restricted since this injury? yes no

Check the symptoms you have experienced since the accident:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Tension across shoulders | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Arm /hand pain | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Numbness in arms/hands/fingers | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Leg/foot pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Numbness in legs/feet/toes | <input type="checkbox"/> Nausea | <input type="checkbox"/> Other _____ |

Is your condition getting worse? yes no

Is your condition aggravated by any of the following?

- | | | | |
|-----------------------------------|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lying on back | <input type="checkbox"/> Working | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Lying on side | <input type="checkbox"/> Lifting | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Lying on stomach | <input type="checkbox"/> Bending | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Running | <input type="checkbox"/> Resting | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Other _____ |

Please provide any additional information that we should know: _____

Patient Name (printed)

Patient Signature

Date