ACCIDENT HISTORY

DATE OF ACCIDENT_____TIME_____

DESCRIBE HOW THE ACCIDENT HAPPENED:_____

_____

_____

Did your vehicle strike Another Car__A Sign__A Tree__A Bridge___A Hedge____An Embankment____

Were you driving **Y N** Was it your car? **Y N** If no, who's_____

Passenger? Front__Back__Right Side__Left Side__ Were you rotated in seat **Y N** Seat belt on? **Y N**

Shoulder harness on? **Y N** Was it Daylight?__Night__Dusk__Dawn__

What were the weather conditions?_____What were the traffic conditions?_____

What was the posted speed limit?_____How fast were you going?_____

Did if happen at an intersection? **Y N** If yes, at a stop sign____or traffic light____

Type of road :Two Lane___Four Lane__Gravel___Tar___Was you car hit Front__Back___L Side___R Side___

Did your vehicle go off the road? **Y N** If yes where? A Ditch__An Embankment__How Deep?_____

If you struck another car, did you strike the: Front__Back__Side__

What type of vehicle were you driving? Make_____Year_____

What was the type of the other vehicle involved in the accident? Car___Truck__Motorcycle__
Make_____Year_____

Was there a ticket issued? **Y N** if yes Who?_____Violation?_____

By Police of City_____County_____State_____
Please provide a copy of the police report if possible

Were you completely conscious after the impact? **Y N** Do you remember the impact? **Y /N**
Does it bother you to ride in a car now? **Y N** If yes a Driver____Passenger____
State any strange events that happened during or immediately after the accident_____

_____
Have you had any time loss from work? **Y N** If yes Explain_____
Have you had to have outside help **Y N** If yes Explain_____
Have you retained an attorney? **Y N** If yes provide name and address_____

_____

Patient Signature_____Date_____

Smith Chiropractic Offices, P.C.
AUTOMOBILE ACCIDENT QUESTIONNAIRE

NAME:_____DATE_____

GENERAL SYMPTOMS

Did you hit any part of your body during the collision: for example, head on dash chest on steering wheel? **Y N**
If yes which part and how?_____

Where were you taken after the accident?_____

Were you hospitalized? **Y N** If yes list doctors or other health care specialist?

_____

What type of care were you given and for how long?_____

Symptoms Immediately after the accident?_____

_____

If symptoms were not immediate, when did they occur and what were they?_____

_____

Current Symptoms_____

_____

Pain Rating

How long have you had this pain?_____
Within the last couple of days to a week please rate your level of pain and frequencies. Pain Levels: Using a 0-10 Pain scale (O=No Pain 10= Most intense pain imaginable)
Rate your current level of pain_____, percent of time at this level of pain _____%
Rate your average pain level _____, percent of time at this level of pain_____%
Rate the worst your pain gets_____, percent of time at this level of pain_____%
Rate the lowest your pain gets_____, percent of time at this level of pain_____%

What things are you unable to do or must modify to perform?_____

_____

What will bring on or intensify your pain?_____

_____

Past History Relevant to Present Condition (Accidents, Injuries,Disabilities)_____

_____

Have you ever had complaints in involved area before? **Y N** If yes what were the complaints?_____

_____

PLEASE COMPLETE THIS FORM ON THE BACK