ACCIDENT/INJURY QUESTIONNAIRE

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

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ No ☐ Yes - *(Number of people)* _____
- **You were?** ☐ Front seat – *Driver Passenger* ☐ Rear Seat– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy?** ☐ No ☐ Yes **Did Police arrive?** ☐ No ☐ Yes **Using Seatbelt?** ☐ No ☐ Yes
- **Did you strike the windshield or object in car?** ☐ No ☐ Yes - *(Describe)* _____
- **Were you knocked unconscious?** ☐ No ☐ Yes *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ **Occupation:** _____ **Claim #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Contact Person: _____ **Phone:** _____ **Email:** _____

GENERAL ACCIDENT/INJURY INFORMATION – *(PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Date of Accident: ____/____/_____ **Time:** ___:_____ AM / PM

Please describe the accident in as much detail as possible? _____

_____

_____

_____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ No ☐ Yes
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ No ☐ Yes
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction?** ☐ No ☐ Yes

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? _____
- **Were you taken anywhere after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? _____
  - *If yes,* **How?**_____ **Where?**_____
  - *If yes,* **Did you receive treatment?** ☐ No ☐ Yes - *(Describe)* _____

Since the accident/injury:

- **Are your symptoms:** ☐ Improving? ☐ Getting Worse? ☐ The Same?
- **Are your work activities restricted as a result of this accident/injury?** ☐ No ☐ Yes - *(How?)* _____
- **Have you missed any work since this accident?** ☐ No ☐ Yes - *(Dates?)* _____
- **Have you retained an Attorney?** ☐ No ☐ Yes - **Name:**_____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Patient No: _____

Functional Loss Assessment

Today's Date:
Name:
Date of Accident:

As a direct result of my accident, I have the following problems that I didn't have before the accident:

PERSONAL LIMITATIONS: Since the accident I can no longer do the following as I did prior to the accident:

bathing	grooming	cooking	cleaning	vacuuming	Yard work	groceries	shopping
sexual	difficulties	watching TV	reading	shaving	driving	shoveling	sleeping

SOCIAL LIMITATIONS: Since the accident I can no longer do the following as I did prior to the accident:

dancing	movies	theater	walking	running	bicycling	concerts	sports
gardening	mowing	painting	exercising	child care	swimming	decorating	shopping

WORK LIMITATIONS: Since the accident I can no longer do the following as I did prior to the accident:

lifting	carrying	bending	pulling	pushing	pinching	gripping	sitting
standing	bending	twisting	phone time	computer	focusing	awareness	climbing

A common item is **memory and/or cognitive** (ability to function mentally) **loss**. Please complete the above in complete sentences if possible.

Patient Signature