Highland Park *Spine & Sports Medicine*

Accident Questionnaire

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____Apt No: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) - _____ - _____ Work Phone: (_____) - _____ - _____

Alternate Phone: (_____) - _____ - _____ Cell/Pager (_____) - _____ - _____

Email:

_____

Age: _____ Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Social Security No.: _____ / _____ / _____

Description of the Accident:

1. Briefly describe the cause of injury: (e.g.: location of accident, how it happened, etc.)

_____

_____

_____

2. If you have retained an attorney,please provide the following information:

Attorney's Name:_____ Phone No.: (_____) - _____ - _____

Address: _____

City:_____ State:_____ Zip: _____

3. Identity of other parties who may be responsible for injuries:

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____Apt No: _____

City:_____ State: _____ Zip: _____

Name of insurance company responsible for the claim (e.g.: auto, homeowners, worker's comp, etc.)

_____

Insurance company address: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Policy No.: _____

Adjuster's Name: _____

Phone No.: (_____) - _____ - _____ Claim No.: _____

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Accident Questionnaire

NATURE OF ACCIDENT:

1. Date of Accident: _____ / _____ / _____ Time of Day: _____

2. Were you: ❑ Driver ❑ Passenger ❑ Front Seat ❑ Back Seat

3. Number of people in your vehicle: _____ Were you wearing seat belt?: ❑ Yes ❑ No

4. What direction were you headed?: ❑ North ❑ East ❑ South ❑ West

On (name of street)

_____

5. What direction was the other vehicle headed?: ❑ North ❑ East ❑ South ❑ West

On (name of street)

_____

6. Were you struck from: ❑ Behind ❑ Front ❑ Left Side ❑ Right Side

7. Approximate speed of your car:_____ (mph) Other car:_____ (mph)

8. Were you rendered unconscious?: ❑ Yes ❑ No If yes, for how long? _____

9. Were police notified?: ❑ Yes ❑ No

10. In your own words, please describe the accident:

_____

_____

_____

_____

11. Did you have any physical complaints BEFORE the accident?: ❑ Yes ❑ No If yes, please describe in detail:

_____

_____

_____

_____

12. Please describe how you felt:

a. DURING the accident:

_____

_____

b. IMMEDIATELY AFTER the accident:

_____

_____

c. LATER THAT DAY:

_____

_____

d. THE NEXT DAY:

_____

_____

(continued to next page)

13. What are your PRESENT complaints and symptoms?:

_____

_____

14. Do you have any previous illnesses which relate to this case?: ❑ Yes ❑ No If yes, please describe in detail:

_____

_____

15. Have you ever been involved in an accident before?: ❑ Yes ❑ No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:

_____

_____

16. Where were you taken after the accident?: ❑ Hospital ❑ Doctor's Office ❑ Home ❑ Other: _____

17. Have you been treated by another doctor since the accident?: ❑ Yes ❑ No If yes, please list the doctor's name and address.

Last Name: _____ First Name: _____

Address: _____

City:_____ State:_____ Zip: _____

What type of treatment did you receive?

_____

_____

18. Since the injury occurred, are your symptoms: ❑ Improving ❑ Getting Worse ❑ Same

19. Check any symptoms you have noticed since the accident:

❑ Headache	❑ Irritability	❑ Numbness in Toes	❑ Face Flushed	❑ Feet Cold
❑ Neck Pain	❑ Chest Pain	❑ Shortness of Breath	❑ Buzzing in Ears	❑ Hands Cold
❑ Stiff Neck	❑ Dizziness	❑ Fatigue	❑ Loss of Balance	❑ Stomach Upse
❑ Sleeping Problems	❑ Head Seems Too Heavy	❑ Depression	❑ Fainting	❑ Constipation
❑ Back Pain	❑ Pins &Needles in Arms	❑ Lights Bother Eyes	❑ Loss of Smell	❑ Cold Sweats
❑ Nervousness	❑ Pins &Needles in Legs	❑ Loss of Memory	❑ Loss of Taste	❑ Fever
❑ Tension	❑ Numbness In Fingers	❑ Ears Ring	❑ Diarrhea	

Symptoms other than above:

_____

20. Have you lost time at work as a result of this accident?: ❑ Yes ❑ No If yes, please complete these questions:

a. Last day worked: _____ / _____ / _____

b. Type of employment: _____

c. Are you being compensated for time lost from work?: ❑ Yes ❑ No

21. Do you notice any activity restrictions as a result of this injury?: ❑ Yes ❑ No If yes, please describe in detail:

_____

_____

22. Other pertinent information: _____

Patient's Signature: _____ Date : _____ / _____ / _____