

Patient # _____

Accidental Injury History

Date: _____

Automobile Accident Questionnaire

Name: _____ Date of injury: _____

Please describe the accident circumstances completely:

List the Extent of the injuries as you know them:

Circle the symptoms you have had since the accident:

Head injuries:

- Headaches
- Loss of memory
- Loss of hearing
- Lightheadedness
- Fainting
- Eye pain
- Loss of Balance
- Dizziness
- Loss of hearing
- Pain in the ears
- Ear noises
- Concussion
- Lights bother eyes
- Loss of smell or taste

Abdominal symptoms:

Stomach, nausea, indigestion, gas, constipation, diarrhea

Low Back Symptoms:

- Low back pain: Back is aggravated by working, lifting, stooping, or standing sitting, bending, coughing, or lying down
- Disc problems
- Difficulty in Standing

Leg Injuries:

- Numbness extending into right or left leg
- Pain into Buttocks, Knee joint, calves or ankles
- Feet are cold
- Swollen ankles
- Pain in the hip, knee, ankles or feet

Neck Injuries:

- Stiffness, Soreness of the neck
- Muscle spasm in the neck
- Difficult neck movement
- Grinding sounds in the neck

General Symptoms:

- Depression
- Fatigue
- Insomnia
- Loss of weight
- Frequent urination
- Nervousness
- Jitteriness
- Bruises
- Lacerations
- Broken bones
- Knocked unconscious or stunned

Shoulders, arms and chest injuries:

- Shoulder pain, right or left
- Pain between the shoulders
- Can't raise arm or hand
- Numbness or pain in arms, hands, or fingers
- Cold hands
- Shoulder, elbow or wrist pain
- Loss of strength in arms or hands
- Chest pain
- Shortness of breath
- Rib pain
- Carpal tunnel syndrome

Other:

Have you consulted with other Doctors for your injuries? _____ Yes _____ No

Did you report the injury to your foreman, employer, or police? _____ Yes _____ No

TYPE OF ACCIDENT

If auto accident, were you _____ driver _____ passenger _____ pedestrian

If auto accident were you struck from _____ behind _____ right side _____ left side _____ front

If at work, describe details: _____
