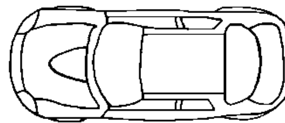
BEMIS CHIROPRACTIC CLINIC

ACCIDENT HISTORY QUESTIONNAIRE

PERSONAL INJURY PATIENT HISTORY

Name: ____ Date: ______________

1. Date of Accident: ____________________ 2. Time of Accident: _________________AM/PM
3. Who was the driver of the vehicle: ____
4. Where were you seated in the vehicle? ____
5. Who owns the vehicle? ____
6. Year & Model of your vehicle: ____
7. What was the approximate dollar damage done to your vehicle? __________________________
8. Visibility at the time of the accident: ☐ poor ☐ fair ☐ good ☐ other ______________
9. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark
   ☐ other (describe) ____
10. Where was the vehicle struck?



    In your own words, please describe the accident: ____________________________________
    ____
    ____
11. Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Front Impact
    ☐ Rear-ended car in front ☐ Rear Impact ☐ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your vehicle: ____
13. Did you see the accident coming? ☐ yes ☐ no
14. Were you able to brace for impact? ☐ yes ☐ no
15. Were you wearing a seatbelt? ☐ yes ☐ no
16. Were shoulder harnesses worn? ☐ yes ☐ no
17. Does your vehicle have headrest? ☐ yes ☐ no
18. If yes, what was the position of the headrests compared to your head before the accident?
    - ☐ Top of headrest even with **bottom** of head
    - ☐ Top of headrest even with **top** of head
    - ☐ Top of headrest even with **middle** of neck
19. Was your vehicle braking? ☐ yes ☐ no
20. Was your car moving at the time of the accident? ☐ yes ☐ no
21. If yes, how fast would you estimate you were traveling? _________ mph
22. How fast would you estimate the other care was going? _________ mph
23. Head/Body position at the time of impact:
    ☐ Head turned left or right ☐ Body straight in sitting position
    ☐ Head looking back ☐ Body rotated right or left

☐ Head straight forward ☐ Other: ____________________

24. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock
    ☐ Dazed, circumstances vague ☐ Other: ____________________
25. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
26. Were you wearing a hat or glasses? ☐ yes ☐ no
27. Could you move all parts of your body? ☐ yes ☐ no
28. If no, what parts couldn't you move and why? ____________________
    ____
29. Were you able to get out of the vehicle and walk unaided? ☐ yes ☐ no
30. If no, why not? ____________________
31. Did you receive any bleeding cuts? ☐ yes ☐ no If yes, where? ____________________
32. Did you receive any bruises? ☐ yes ☐ no If yes, where? ____________________
33. Please describe how you felt:
    Immediately after the accident: ____________________
    Later that day: ____________________
    The next day: ____________________
34. Check the symptoms apparent since the accident:

☐ Headache	☐ Neck pain/stiffness	☐ Mid back pain
☐ Eyes Light Sensitive	☐ Pain behind eyes	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in fingers
☐ Numbness in toes	☐ Loss of smell	☐ Loss of taste
☐ Loss of memory	☐ Fatigue	☐ Shortness of breath
☐ Irritability	☐ Depression	☐ Ringing/buzzing in ears
☐ Loss of balance	☐ Tension	☐ Cold hands
☐ Cold feet	☐ Diarrhea	☐ Constipation
☐ Chest pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial pain	☐ Clicking or popping jaw
☐ Low back pain	☐ Nausea	☐ Other

____
____
____

35. Occupation: ____________________
36. Employer: ____________________
37. Have you missed time from work? ☐ yes ☐ no
38. If yes, full time off work: ____________________ to ____________________
39. If yes, part time of work: ____________________ to ____________________
40. Did you seek medical help immediately after the accident? ☐ yes ☐ no
41. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me
    ☐ Drove own vehicle ☐ Other: ____________________
    ____
42. Doctor first seen: Name: ____________________
43. First visit date: ____________________

44. Were you examined? ☐ yes ☐ no
45. Were x-rays taken? ☐ yes ☐ no
46. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars
47. If yes, what kind of treatment did you receive? ____

____

48. What improvements did you experience from the treatment? ____________________________

____

49. Date of last treatment: ________________________________
50. Second doctor seen: Name: ____
51. First visit date: _________________________________
52. Were you examined? ☐ yes ☐ no
53. Were x-rays taken? ☐ yes ☐ no
54. Did you receive treatment? ☐ yes ☐ no ☐ Medications ☐ Braces ☐ Collars
55. If yes, what kind of treatment did you receive? ____

____

56. What improvements did you experience from the treatment? ____________________________

____

57. Date of last treatment: ________________________________
58. Do you have an attorney on this claim? ☐ yes ☐ no
59. If yes, who? ____

Address: ____

City: ___________________________________ State: ______ Zip: _______________________

Telephone: _______________________________ Email: _________________________________

60. Illustrate below how the accident happened:

61. Past Medical History: Place an (X) if it applies and describe.

☐ Not related to current complaints ☐ Hospital or operations ☐ Auto Accident

☐ Work Accident ☐ Illness ☐ Other

Describe: ____

____

____

____

____

62. Family History: Place an (X) if any family member has had any of the following:

☐ Tuberculosis	☐ Kidney Disease	☐ Spinal Disorder
☐ Mental Illness	☐ Epilepsy	☐ Diabetes
☐ Gout	☐ Allergy	☐ Arthritis
☐ Hypertension	☐ Cancer	☐ Migraines
☐ Heart Disease	☐ Other ______________________________	

63. Personal History: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower

64. Number of children: ________________ How many are living at home: ______________

65. Are you pregnant? ☐ yes ☐ no ☐ not sure

66. Medications, describe: ____

____

____

67. Disease, describe: ____

____

____

68. Other, describe: ____

____

Subjective Pain Level
On a scale of 0-10 place an (X) in
Your current pain level:

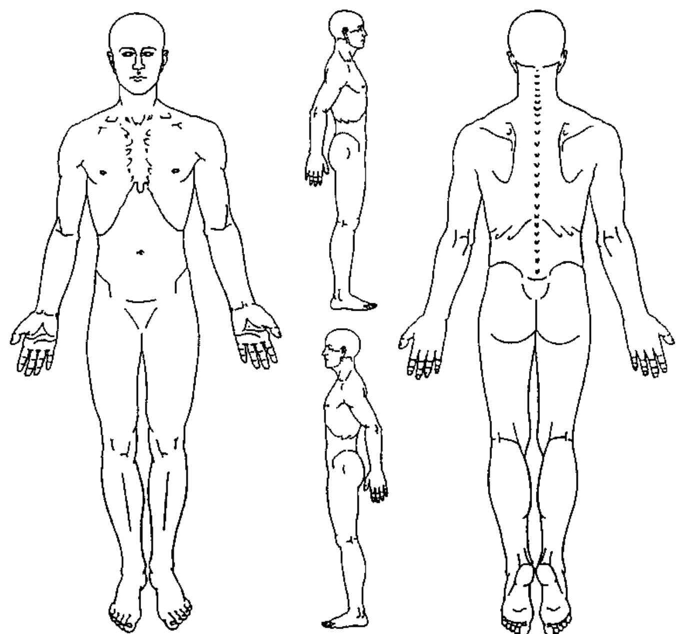
No Pain
☐ 0

Low Pain
☐ 1 ☐ 2 ☐ 3

Moderate Pain
☐ 4 ☐ 5 ☐ 6

Intense Pain
☐ 7 ☐ 8 ☐ 9

Emergency
☐ 10



Mark the areas on your body where you feel the described sensations below. Use the appropriate symbol for each area. Include all regions that are affected.

X NUMBNESS + BURNING O PINS & NEEDLES = STABBING

SYSTEMS REVIEW

Place a (X) next to the symptoms you are experiencing

Genito-Urinary System

☐ Bladder trouble	☐ Excessive urination	☐ Scanty urination
☐ Painful urination	☐ Discolored urine	

Gastro-Intestinal System

☐ Poor appetite	☐ Excessive hunger	☐ Difficult chewing
☐ Difficult swallowing	☐ Excessive thirst	☐ Nausea
☐ Vomiting food	☐ Abdominal pain	☐ Diarrhea
☐ Constipation	☐ Black stool	☐ Bloody stool
☐ Hemorrhoids	☐ Liver trouble	☐ Gall Bladder trouble
☐ Weight problems		

Nervous System

☐ Numbness	☐ Loss of feeling	☐ Paralysis
☐ Dizziness	☐ Fainting	☐ Headaches
☐ Muscle twitching	☐ Convulsions	☐ Forgetfulness
☐ Confusion		

Cardio-Vascular System

☐ Chest pain	☐ Pain over heart	☐ Difficult breathing
☐ Persistent cough	☐ Coughing up phlegm	☐ Coughing blood
☐ Rapid heartbeat	☐ High blood pressure	☐ Heart problems
☐ Lung problems	☐ Varicose veins	☐ Other

Eye, Ear, Nose and Throat System

☐ Eye strain	☐ Eye inflammation	☐ Vision problems
☐ Ear pain	☐ Ear noises	☐ Ear discharge
☐ Hearing loss	☐ Nose pain	☐ Nose bleeding
☐ Nose discharge	☐ Breathing difficulty	☐ Sore gums
☐ Sore mouth	☐ Sore throat	☐ Hoarseness
☐ Speech difficulty	☐ Dental problems	

Activities of Daily Living Assessment

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

Section 1 Pain Intensity

☐ I can tolerate the pain I have without using painkillers.
☐ The pain is bad, but I manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers give no relief from pain and I do not use them.

Section 2 Personal Care (washing, dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally, but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help, but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights, but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on table).
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I lift only very light weights.
☐ I cannot lift or carry anything at all.

Section 4 Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than ½ mile.
☐ Pain prevents me from walking more than ¼ mile.
☐ I can only walk using a cane or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 Sitting

☐ I can sit in any chair as long as I would like.
☐ I can sit only in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 15 minutes.
☐ Pain prevents me from sitting at all.

Section 6 Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want, but it causes extra pain.
☐ Pain prevents me from standing for more than one hour.
☐ Pain prevents me from standing for more than 30 minutes.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using sleeping tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 Sex Life

☐ My sex life is normal and causes no extra pain.
☐ My sex life is normal, but causes some extra pain.
☐ My sex life is nearly normal, but is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is nearly absent because of pain
☐ Pain prevents any sex life at all.

Section 9 Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal, but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.)
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 10 Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere, but it gives me extra pain.
☐ Pain is bad, but I manage journeys over 2 hours.
☐ Pain restricts me to the journeys of less than one hour.
☐ Pain restricts me to short necessary trips under a ½ hour.
☐ Pain restricts me from traveling except to the doctor or hospital.

____ ________________________

Patient Signature Date