# Accident History Questionnaire

## PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

Address _____ Phone Number _____

Cell Phone _____ Email _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____ 4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car. _____

   Year & Model of other car. _____
7. What was the approximate damage done to your car? $ _____
8. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other: _____
9. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark ☐ other (describe): _____
10. Where was your car struck?

    FRONT  REAR

    In your own words, please describe accident: _____
11. Type of Collision: ☐ Head-on ☐ Broad-side ☐ Front Impact ☐ Rear-end 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 car: _____
13. Did you see the accident coming? ☐ yes ☐ no
14. Did you brace for impact? ■ yes ☐ no
15. Were seatbelts worn? ☐ yes ☐ no
16. Were shoulder harnesses worn? ■ yes ☐ no
17. Does you car have headrests? ☐ yes ☐ no
18. If yes, what was the position of those 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 car 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 going? _____ mph
22. the other car? _____ mph
23. Head/Body position at the time of impact:

    ☐ Head turned left/right ☐ Head looking back ■ Head straight forward

    ☐ Body straight in sitting position ☐ Body rotated right/left ■ 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 car and walk unaided? ☐ Yes ☐ No
30. If no, why not? _____
31. Did you get any bleeding cuts? ☐ yes ☐ no If yes, where? _____
32. Did you get any bruises? ☐ yes ☐ no If yes, where? _____
33. Describe how you felt immediately after the accident: _____

    Later that day: _____

    The next day: _____

34. Check symptoms apparent since the accident:

| | | | | |
|---|---|---|---|---|
| ☐ Headache | ☐ Chest pain | ☐ Neck pain/Stiffness | ☐ Mid back pain | ☐ Light sensitivity |
| ☐ Anxious/Nervousness | ☐ Pain behind eyes | ☐ Dizziness | ☐ Low back pain | ☐ Sleeping problems |
| ☐ Numbness in fingers | ☐ Loss of smell | ☐ Numbness in toes | ☐ Fainting | ☐ Cold feet |
| ☐ Facial Pain | ☐ Loss of memory | ☐ Fatigue | ☐ Breath shortness | ☐ Loss of taste |
| ☐ Irritability | ☐ Depression | ☐ Ringing/Buzzing | ☐ Cold Sweats | ☐ Loss of balance |
| ☐ Tension | ☐ Constipation | ☐ Cold hands | ☐ Clicking / Popping Jaw | |
| ☐ Diarrhea | ☐ 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 off 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 drove me ☐ Drove myself ☐ Other:_____

42. Doctor #1: 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 benefits did you receive from the treatment?_____

49. Date of last treatment? _____

50. Doctor #2: 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 benefits did you receive 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 _____ Phone _____

Illustrate how the accident happened.

**PAST MEDICAL HISTORY:** Place an (X) if it applies and describe.

☐ None related to current complaints ☐ Hospital or operation ☐ Auto Accident ☐ Work Accident ☐ Illness ☐ Other

Describe _____

_____

## 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 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 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 like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 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 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 1/2 hour.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

## CURRENT CHIEF COMPLAINTS:

Place an (X) in the appropriate complaint areas.

*SPINE*

☐ Low back ☐ Mid back ☐ Neck ☐ Pelvis

*UPPER EXTREMITY*

☐ Shoulder R/L ☐ Arm R/L ☐ Elbow R/L
☐ Wrist R/L ☐ Forearm R/L ☐ Hand R/L

*LOWER EXTREMITY*

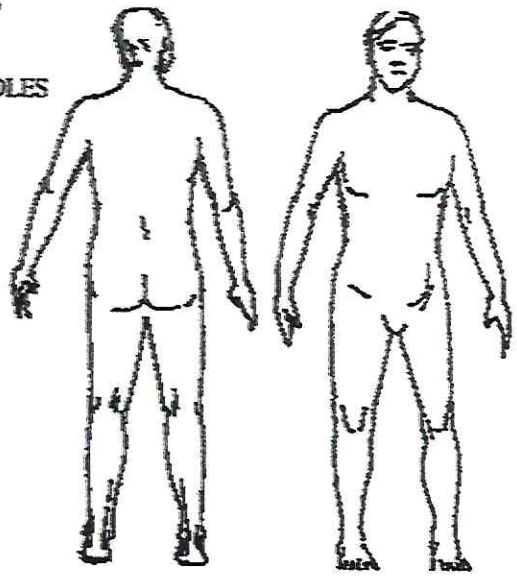
☐ Hip R/L ☐ Thigh R/L ☐ Knee R/L
☐ Leg R/L ☐ Ankle R/L ☐ Foot R/L

*OTHER (describe):* _____

_____

Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

× NUMBNESS
÷ BURNING
○ PIN & NEEDLES
= STABBING



## SUBJECTIVE PAIN LEVEL:

On a scale of 1 - 10, place an (X) in your current pain level

NORMAL ——— EMERGENCY

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

_____

*Patient's Signature*

## FAMILY HISTORY: Place an (X) if any family member has suffered from:

☐ Tuberculosis ☐ Kidney Disease ☐ Spinal Disorder ☐ Mental Illness ☐ Epilepsy
☐ Diabetes ☐ Gout ☐ Allergy ☐ Arthritis ☐ Hypertension
☐ Cancer ☐ Migraines ☐ Heart Attack ☐ Other, list:_____

## PERSONAL HISTORY: Place an (X) if it applies, describe.

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower Employed Spouse? ☐ yes ☐ no

Number of Children _____ Number of Children at home _____ Are you pregnant? ☐ yes ☐ no ☐ not sure

Medications, describe _____

_____

Disease, describe _____

_____

Other, describe_____

## SYSTEM REVIEW Place an (X) next to the symptoms you know you have

### GENITO-URINARY SYSTEM

☐ Bladder trouble ☐ Excessive urination ☐ Scanty urination ☐ Painful urination ☐ Disclosed 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 ☐ Weight trouble ☐ Gall bladder trouble

### NERVOUS SYSTEM

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

### CARDIO-VASCULAR SYSTEM

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

### EYES, EARS, NOSE AND THROAT SYSTEM

☐ Eye strain ☐ Eye inflammation ☐ Vision problems ☐ Ear pain ☐ Ear noises ☐ Ear discharge
☐ Hearing loss ☐ Breathing Difficulty ☐ Nose bleeding ☐ Nose discharge ☐ Sore gums ☐ Nose Pain
☐ 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 pain killers.
☐ The pain is bad but I manage without taking pain killers.
☐ Pain killers give complete relief from pain.
☐ Pain killers give moderate relief from pain.
☐ Pain killers give very little relief from pain.
☐ Pain killers give no relief from pain. I do not use them.

### SECTION 2 : PERSONAL CARE

☐ 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 the 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 a table).
☐ Pain prevents me from lifting heavy weights. I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

BRECKSVILLE PHYSICAL MEDICINE
8930 BRECKSVILLE ROAD
BRECKSVILLE, OH 44141
PHONE: 440-740-0696
FAX: 440-740-0697

**PERSONAL INJURY INSURANCE/PAYMENT INFORMATION**

PATIENT NAME: _____ DATE: _____

DATE OF INJURY: _____

**AUTOMOBILE**

NAME OF PATIENT'S CAR INSURANCE: _____

IS THERE MEDICAL COVERAGE: _____

IF YES, COMPLETE THE REST OF THE SECTION. IF NO, GO TO HEALTH INSURANCE SECTION.

CLAIM NUMBER: _____ (NOT POLICY #)

CLAIM ADJUSTER: _____

ADDRESS FOR CLAIMS CENTER: _____

TELEPHONE NUMBER: _____

**ATTORNEY**

NAME: _____ PHONE NUMBER: _____

ADDRESS: _____

****** Please Give Front Desk any and all insurance cards to make copies for your file. Thanks!**

*Advanced Health and Wellness Center of Ohio, LLC.*
*8930 Brecksville Rd. Brecksville, OH 44141*

# ***Doctor's Lien***

I do hereby authorize the doctor to furnish my attorney, with a full report of my examination, diagnosis, treatment, prognosis etc., in regard to the accident in which I was involved.

I hereby authorize and direct my attorney to pay directly to said doctor, such sums as may be due and owing him for medical services rendered to me, by reason of this injury and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the doctor. I hereby further give a lien on my case to said doctor, against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney or myself, as the result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to said doctor, for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on a current basis.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian (if minor): _____

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The undersigned being attorney record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sum from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above. Should the attorney client relationship between myself and the above referenced individual be terminated for any reason, I agree to notify the doctor's office immediately by phone and confirm such termination by written correspondence.

In the event that it becomes necessary to hire an attorney for the enforcement of this guarantee and or in the event of default by guarantor, guarantor shall provide for court costs and attorney fees not less than 25% of the balance due on the patient's account in addition to said balance due.

Date: _____ Attorney's Signature: _____

Please date, sign and return to doctor's office as soon as possible.