Automobile Accident Questionnaire

Please answer all questions completely.

Name:____ Sex (circle one): M F O Date of Birth:__________________

Please explain in detail how your accident happened:____

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City and Street of Accident:_______________________________________ Date/Time of accident:________________

Your Insurance Co:____________________________ Policy #:______________________ Claim #:__________________

Your Auto Make/Model/Year:____

Estimate of Damage done to your car:_______________________________

Name of Driver in Other Vehicle:___________________________________ Other Driver's Insurance Co:____________

Other Driver's Policy #:_______________________________ Other Driver's Claim #:_______________________________

Other Driver's Auto Make/ Model:____

Have you retained an attorney? ____Yes ____No If yes, who?______________________________________

You were the: ____ Driver ____Passenger You were in the: ____ Front Seat ____Back Seat

Were you wearing a seatbelt with a shoulder harness? ____Yes ____No

Did any airbags deploy? ____Yes ____No If yes: ____Front ____Side

Were you knocked unconscious? ____Yes ____No

Did any body part hit the inside of your car? ____Yes ____No If yes, mark all that apply: ___Dashboard

___Rear Head Rest ___Side Window Other:____

Was any other doctor consulted after your accident? ___Yes ___No If yes, what was the doctors

name:_______________________________________

Were you taken by ambulance to a Hospital ER? ___Yes ___No If yes, which hospital?____________________

Were you examined at a Hospital ER? ___Yes ___No If yes, which hospital?_______________________________

What instructions did the ER doctor release you with?____

____

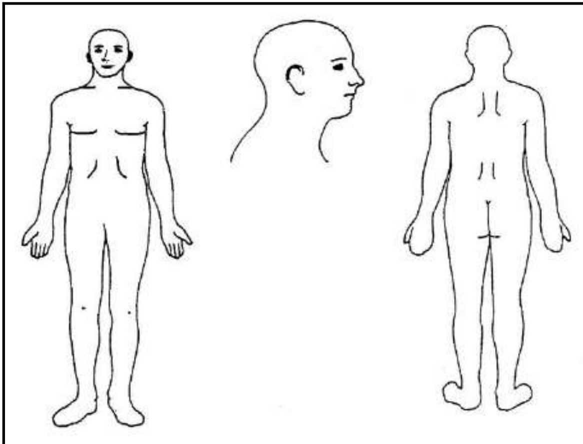
Since this accident, are your symptoms: ___Improving ___Getting worse ___Staying the Same

Health Questionnaire

Please rate each of the following using a 0-10 pain/discomfort scale. Example: 0= no pain ; 10= worst pain imaginable

___Neck Pain ___Headaches ___Dizziness ___Middle Back Pain
___Low Back Pain ___Nausea ___Shoulder Pain ___Difficulty Sleeping
___Arm Pain/tingling/numb ___Leg Pain/numb/tingling ___Weakness ___Fatigue
___Other:__________________ ___Other:_____________________ ___Other:____________________

Please mark the areas you are experiencing pain.



General Pain Disability Index Questionnaire

Please circle the number that best describes your typical level of activities. A score of 0 means no disability at all and 10 meaning that all activities, which you would normally be involved in have been totally disrupted

Family/Home Responsibilites: This category refers to activities related to the home or famliy. It includes chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g driving children to school).

Completely able to function______0_____1_____2_____3______4______5_______6_____7______8______9_______10______Barely unable to function

Recreation: This category includes hobbies, sports and other similar leisure time activities.

Completely able to function______0_____1_____2_____3______4______5_______6_____7______8______9_______10______Barely unable to function

Social Activities: This category referes to activities which involve participation with friends and aquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

Completely able to function______0_____1_____2_____3______4______5_______6_____7______8______9_______10______Barely unable to function

Occupation: This category refers to activites that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer.

Completely able to function______0_____1_____2_____3______4______5_______6_____7______8______9_______10______Barely unable to function

Self Care: This category includes activites that involve personal maintance and independent daily living (e.g. showering, driving, getting dressed).

Completely able to function______0_____1_____2_____3______4______5_______6_____7______8______9_______10______Barely unable to function

Life-Support Activities: This category refers to basic life-supporting activities such as eating, sleeping, and breathing.

Completely able to function______0_____1_____2_____3______4______5_______6_____7______8______9_______10______Barely unable to function

Please do NOT write past this line

Patient accepted? ____Yes ___No Doctor's Signature:____