Automobile Accident Questionnaire

Please answer all questions completely

Name ______________________ Gender __________ Date of Birth ______________

Please explain in detail how your accident happened ______________________________

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Your Insurance Co. ______________ Policy No. ______________ Claim No. ______________

Your Auto Make/Model/Year ______________ Type of damage to auto ______________________

Name of driver of other vehicle (if any) ______________ Other Driver's Insurance Co. __________

Other Driver's Policy No. ______________ *Other Driver's* Claim No. ______________ *Other Driver's* Auto Make/Model ______________

Have you retained an attorney? ❑ Yes ❑ No If yes, who? ______________________

You were the: ❑ Driver *or* Passenger in the: ❑ Front Seat ❑ Back Seat ❑ Using Seat Belts

Location of accident ______________________ Time and date of accident ______________________

Were you knocked unconscious? ❑ Yes ❑ No If yes, for how long? ______________________

Was any other doctor consulted after your accident? ❑ Yes ❑ No If yes, who? ______________

What was the diagnosis? ____

What treatment was given? ____

Since this accident, are your symptoms: ❑ Improving? ❑ Getting worse? ❑ Staying the Same?

Health Questionnaire

Please mark your areas of pain on the figure below

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

____ Neck pain ____ Headaches

____ Middle back pain ____ Dizziness

____ Low back pain ____ Nausea

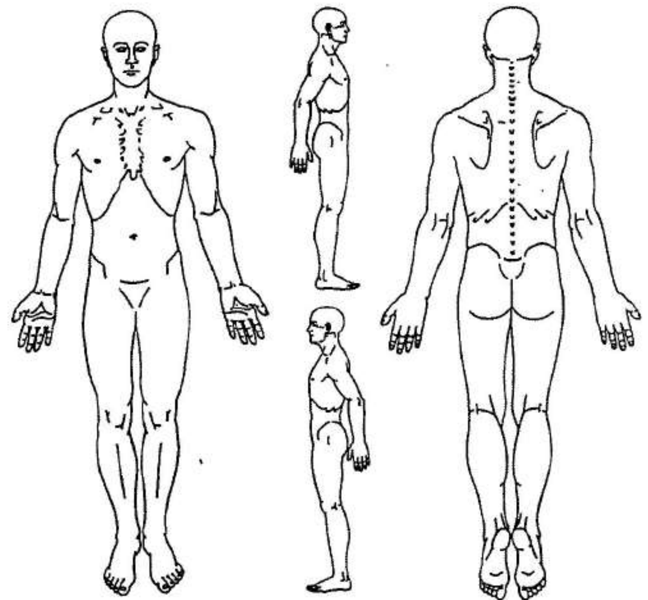
____ Shoulder pain ____ Difficulty Sleeping

____ Arm pain/numb/tingling ____ Other: ___________

____ Leg pain/numb/tingling ____ Other: ___________

____ Weakness ____ Other: ___________

____ Fatigue ____ Other: ___________



General Pain Disability Index Questionnaire

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

FAMILY/HOME RESPONSIBILITIES: This category refers to activities related to the home or family. 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 Totally 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 Totally unable to function

SOCIAL ACTIVITIES: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 Totally unable to function

OCCUPATION: This category refers to activities 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 worker.

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 Totally unable to function

SELF CARE: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed).

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 Totally unable to function

LIFE-SUPPORT ACTVITIES: This category refers to basic life-supporting behaviors such as eating, sleeping, & breathing.

Completely able to function 0 1 2 3 4 5 6 7 8 9 10 Totally unable to function

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Patient accepted? ❑ Yes ❑ No Doctor's signature ______________________________