A Renaissance Health Center for Natural Medicine

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AUTO ACCIDENT QUESTIONNAIRE

Name: ______________________________________ **Date:** ____________

Sex: M F DOB: _____________ Age _________
Address:____
City: ____________________ State: ____________ Zip _________________
Home Phone: _____________ Work: _____________ Cell: _______________
Email: ____

1. Date of Accident: ________________ Time of Accident: ______________ (AM O / PM O)
2. Who was the driver of the car? ____
3. Where were you seated? ____
4. Type of Accident: O head-on collision O broad side collision
   O rear-end collision O front impact,rear-ended car in front
   O non-collision(describe) ____________________________
5. Describe in your own words what happened to you upon impact: ________________________
   ____
6. Did you brace for impact? O Yes O No
7. Were seat belts worn? O Yes O No
8. Were shoulder harnesses worn? O Yes O No
9. Does your car have headrests? O Yes O No
   If yes, what was the position of the headrests compared to your head before the accident?
   O Top of the headrest even with Bottom of head.
   O Top of headrest even with TOP of head.
   O Top of headrest even with MiIDDLE OF NECK.
10. Was your car moving at the time of the accident? O Yes O No
11. How fast was the other car traveling __________mph.
12. What was your head/body position at the time of the impact?
    O head turned left/right O body straight in the sitting position
    O head looking back O body rotated left/right
    O head straight forward O other: _______________________
13. At the time of the accident, recal what parts of your head or body hit what parts of the inside of the car: ____
    ____
14. As a result of the accident you were: O rendered unconscious O dazed, circumstance vague
15. Could you move all parts of your body? O Yes O No
    If no, what parts and why? ____
16. Were you able to get out of the car and walk unaided? O Yes O No
    If no, why not? ____
17. What bleeding cuts did you get from this accident? ______________________________
18. What bruises did you get from this accident? __________________________________
19. Please specify and describe how you felt immediately after the accident: __________________
    ____
    Later that day:

The next day: ____

20. Circle symptoms apparent SINCE the accident:

Headache	Loss of smell	Numbness in fingers
Neck pain/stiffness	Loss of taste	Cold hands
Mid back pain	Loss of memory	Cold feet
Low back pain	Fatigue	Diarrhea
Eyes sensitive to light	Tension	Constipation
Pain behind eyes	Shortness of breath	Chest pain
Dizziness	Irritability	Nervousness
Fainting	Depression	Cold Sweats
Ringing/buzzing in ears	Sleeping problems	Anxious
Loss of Balance	Numbness in toes	Other: _______________

21. Occupation: ______________________________ Employer: ____________________________

22. Have you missed time from work or school because of this accident? ○ Yes ○ No
If yes, unable to work since accident.
○ Full time off work. Dates: _____________________
○ Part-time off work Dates: _____________________

23. Did you go to seek medical help immediately or soon after the accident? ○ Yes ○No
If yes, how did you get there? ○ Someone else drom me ○Ambulence
○ I drove my own car ○Police
○ Other ______________________________________

Doctor/Hospital/Clinic seen? ____
Were you examined? ○ Yes ○ No
Were x-rays taken? ○Yes ○ No If yes, what body parts: ___________________________________
What treatments were you given?
Bed rest brace physiotherapy adjustments drugs
What benefits did you receive from the treatment? ____
Date of last treatement? ____

24. Have you sought or had any treatment other than the doctor listed above? ○ Yes ○ No
If yes, doctor/hospital/clinic: ____
What treatment was given to you? ____

25. Did you have any physical complaints just before the accident? ○ Yes ○ No
If yes, please describe in detail: ____
____
____

Signature of Patient: Date:

____ ________________