



A Renaissance Health Center for Natural Medicine

130 NW Miller Ave., Gresham, OR 97030

phone 503.665.2344

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 / PM)
2. Who was the driver of the car? _____
3. Where were you seated? _____
4. Type of Accident: head-on collision broad side collision
 rear-end collision front impact, rear-ended car in front
 non-collision(describe) _____
5. Describe in your own words what happened to you upon impact: _____

6. Did you brace for impact? Yes No
7. Were seat belts worn? Yes No
8. Were shoulder harnesses worn? Yes No
9. Does your car have headrests? Yes No
If yes, what was the position of the headrests compared to your head before the accident?
 Top of the headrest even with Bottom of head.
 Top of headrest even with TOP of head.
 Top of headrest even with MiDDLE OF NECK.
10. Was your car moving at the time of the accident? Yes No
11. How fast was the other car traveling _____ mph.
12. What was your head/body position at the time of the impact?
 head turned left/right body straight in the sitting position
 head looking back body rotated left/right
 head straight forward 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: rendered unconscious dazed, circumstance vague
15. Could you move all parts of your body? Yes No
If no, what parts and why? _____
16. Were you able to get out of the car and walk unaided? Yes 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 Ambulance

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 treatment? _____

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:
