Patient #_____ **Accidental Injury History** Date:_____

Automobile Accident Questionnaire
Name:_____ Date of injury:_____

Please describe the accident circumstances completely:

_____

_____

_____

List the Extent of the injuries as you know them:

_____

_____

_____

Circle the symptoms you have had since the accident:

Head injuries:
Headaches
Loss of memory
Loss of hearing
Lightheadedness
Fainting
Eye pain
Loss of Balance
Dizziness
Loss of hearing
Pain in the ears
Ear noises
Concussion
Lights bother eyes
Loss of smell or taste

Neck Injuries:
Stiffness, Soreness of the neck
Muscle spasm in the neck
Difficult neck movement
Grinding sounds in the neck

Shoulders, arms and chest injuries:
Shoulder pain, right or left
Pain between the shoulders
Can't raise arm or hand
Numbness or pain in arms, hands, or fingers
Cold hands
Shoulder, elbow or wrist pain
Loss of strength in arms or hands
Chest pain
Shortness of breath
Rib pain
Carpal tunnel syndrome

Abdominal symptoms:
Stomach, nausea, indigestion, gas, constipation, diarrhea

Low Back Symptoms:
Low back pain: Back is aggravated by working, lifting, stooping, or standing sitting, bending, coughing, or lying down
Disc problems
Difficulty in Standing

Leg Injuries:
Numbness extending into right or left leg
Pain into Buttocks, Knee joint, calves or ankles
Feet are cold
Swollen ankles
Pain in the hip, knee, ankles or feet

General Symptoms:
Depression
Fatigue
Insomnia
Loss of weight
Frequent urination
Nervousness
Jitteriness
Bruises
Lacerations
Broken bones
Knocked unconscious or stunned

Other:

_____

_____

_____

_____

Have you consulted with other Doctors for your injuries? _____Yes _____No
Did you report the injury to your foreman, employer, or police? _____Yes _____No

TYPE OF ACCIDENT
If auto accident, were you _____driver _____passenger _____pedestrian
If auto accident were you struck from _____behind _____right side _____left side _____front
If at work, describe details:_____
