

AUTO INJURY QUESTIONNAIRE

PLEASE PRINT CLEARLY. If a question does not apply, print NA. If you do not know the answer, leave the question blank.

Patient Name: _____ Today's date: _____

Address: _____

Your Insurance company: _____

Policy Number or Claim number if known _____

Agent: _____

Date of accident: _____

Were you the: Driver Passenger

If passenger, where were you seated? _____

Were you wearing a seat belt? YES NO

Did your vehicle strike another vehicle? YES NO

Was your vehicle struck by another vehicle? YES NO

Did you brace for impact? YES NO

Which way were you facing at impact? Straight ahead back left right not sure

Using your own words, please describe the accident :

Did your body have contact with: (If yes, please indicate body part in the line given.)

Steering wheel _____

Windshield _____

Left side door _____

Right side door _____

Left side window _____

Right side window _____

Roof _____

Dashboard _____

Other _____

Have you gone to the hospital or seen any other Doctor?

YES NO

If yes, name the facility and the Doctor

Date of examination:

Describe any treatment you received:

(Example: x-rays, medications, recommendations, surgery)

PLEASE DESCRIBE HOW YOU FELT:

Immediately after the incident: _____

Later that day: _____

The next day: _____

Is your condition getting worse? YES NO CONSTANT COMES AND GOES

Have you lost any time from work because of this incident? YES NO

Have you retained an attorney: YES NO

If yes, whom: _____

Please circle the symptoms that you have noticed as a result of this incident:

Dizziness

Tension

Cold sweats

Difficulty sleeping

Blurred vision

Pins and needles

Headaches

Memory loss

Neck pain

Nausea

Upset stomach

Shoulder pain

Chest pain

Numbness

Back pain

Fatigue

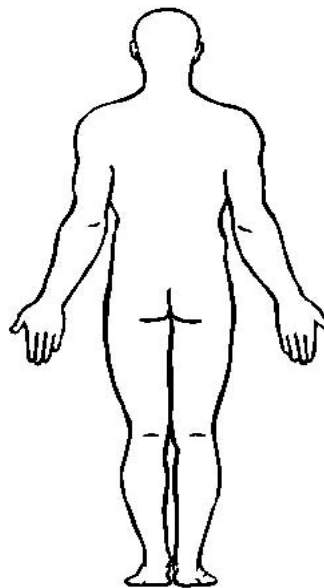
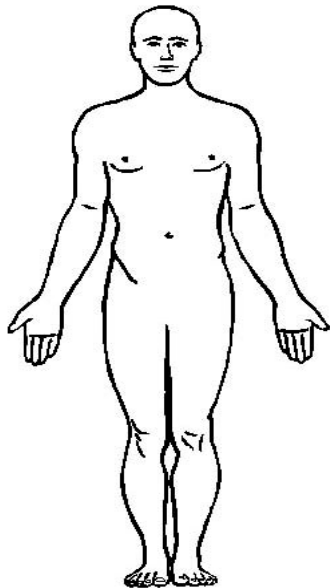
Irritability

Kidney problems

Extremity pain (please explain) _____

Height _____ Weight _____

Please mark the area (s) of injury or discomfort. Mark with the degree of pain on a scale from 1 (discomfort) to 10 (extreme pain).



Other comments you would like to add: _____

Please mark an "X" under the category that best describes your capabilities:

OK = You have not noticed symptoms with this task.

DISCOMFORT = You can do it, but it bothers or irritates you then or later on.

PAINFUL = You may still be able to do it but causes pain every time you do.

UNABLE = The pain is so bad that you cannot do it all.

Daily Activities

	OK	DISCOMFORT	PAINFUL	UNABLE TO DO
Driving				
Shopping				
Vacuuming				
Mopping				
Showering				
Washing dishes				
Lawn work				
Child Care				
Cooking				
Sleeping				
Bending				
Twisting				
Kneeling				
Typing				
Squatting				
Standing				
Sitting				

Recreational Activities

	OK	DISCOMFORT	PAINFUL	UNABLE TO DO
Walking				
Biking				
Golf				
Tennis				
Running				
Horseback riding				
Baseball				
Fishing				
Dancing				
Skiing				
Boating				
Volleyball				
Swimming				
Treadmill				
Weight lifting				

Patient's Signature: _____ Date _____