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: _____

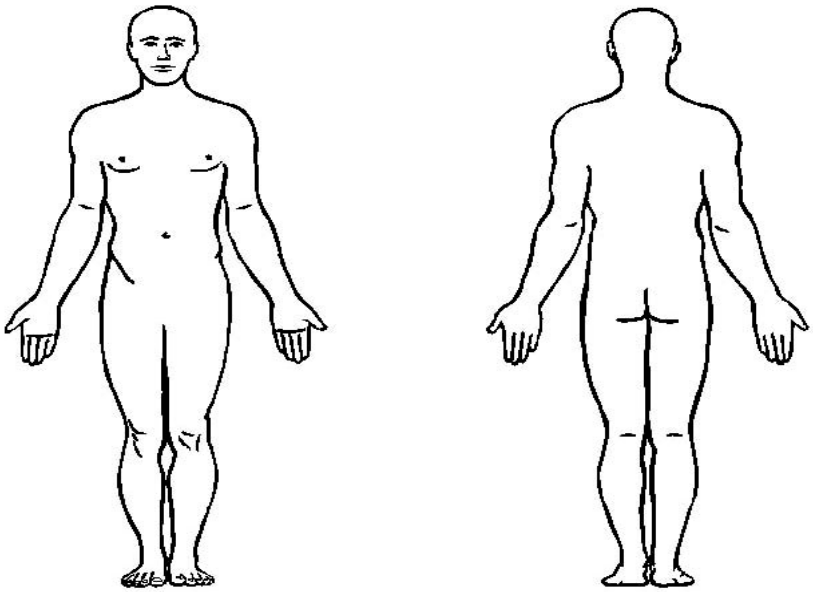
Please circle the symptoms that you have noticed as a result of this incident:

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 _____