AUTOMOTIVE CRASH QUESTIONNAIRE

Patient's Name: ______________________________________ Date: ______________

State Driver's License #: ______________________________

Name of Insurance Company: ____

Name of Insured: ________________________ Claim #: _____________________

Date of Injury: _________________________ Time of Injury: ____________________

What city did the crash occur in? ____

What is the estimated damage to your vehicle? _______________________________

Who made the damage estimates on your car? _______________________________

Who owns the vehicle you were involved in? _________________________________

Who was responsible for the accident? ______________________________________

❑ Yes ❑ No Did you report the injury to the insurance company?

❑ Yes ❑ No Have you filed for Personal Injury Protection "PIP" benefits with your auto insurance company?

❑ Yes ❑ No Do you have an attorney for this case? If yes,

Name of Attorney: ______________________________

Address: _____________________________

____

Phone: __________________

❑ Yes ❑ No Was the accident on the job?

❑ Yes ❑ No Did the police come to the accident scene and make a report?

❑ Yes ❑ No Were you cited by the police?

Describe how the crash happened: ____

____

____

____

____

Draw a diagram of the accident scene. Be sure to label street names, intersections, etc.

COLLISION DESCRIPTION

What type of accident were you involved in? (Check all that apply.)

❑ single car crash ❑ two-vehicle crash ❑ three or more vehicles
❑ rear end collision ❑ sideswipe crash ❑ rollover
❑ head on collision ❑ hit guardrail/tree ❑ ran off road

You were the: ❑ driver ❑ front passenger ❑ rear passenger

Describe the vehicle you were in:

Make and model: ____ Year: ____________
❑ compact car ❑ mid-sized car ❑ full-sized car
❑ pick-up truck/sports utility ❑ large truck/large SUV ❑ large bus or semi-truck

If any, describe the other vehicle(s):

❑ compact car ❑ mid-sized car ❑ full-sized car
❑ pick-up truck/sports utility ❑ large truck/large SUV ❑ large bus or semi-truck

Estimated crash speeds:

Estimate how fast your vehicle was moving at the time of the crash: ________mph
Estimate how fast the other vehicle was moving at the time of the crash: ________mph

At the time of impact, YOUR vehicle was:

❑ slowing down ❑ gaining speed ❑ stopped ❑ moving at a steady speed

At the time of impact, the OTHER vehicle was:

❑ slowing down ❑ gaining speed ❑ stopped ❑ moving at a steady speed

During and after the crash, YOUR vehicle:

❑ kept going straight, not hitting anything ❑ spun around, not hitting anything
❑ kept going straight, hitting car in front ❑ spun around, hitting another car
❑ was hit by another vehicle ❑ spun around, hitting object (not a car)

Describe yourself during the crash:

❑ Yes ❑ No You were aware of the impending collision. Did you see or hear brakes prior to the impact?
❑ Yes ❑ No Were relaxed before impact?
❑ Yes ❑ No Did you brace yourself before impact?
❑ Yes ❑ No Was your body, torso, and head facing straight ahead?
❑ Yes ❑ No Was your head &/or torso turned to the *left* at the time of collision?
❑ Yes ❑ No Was your head &/or torso turned to the *right* at the time of collision?
❑ Yes ❑ No Were you intoxicated (alcohol) at the time of the crash?
❑ Yes ❑ No Were you wearing a seatbelt?
❑ Yes ❑ No Does your seatbelt have a shoulder harness?
❑ Yes ❑ No Were you holding onto the steering wheel at the time of impact?
❑ Yes ❑ No If you were involved in a rear-end crash, did your car separate away from the striking vehicle after the crash? If so, you are indicating that after the crash, your car was pushed away from the striking vehicle.

Indicate if your body hit something or if your body was hit by any of the following. Please draw lines, matching the left side to the right side.

head	windshield
face	side window
shoulder	side door
arm/hand	dashboard
front chest wall	knee bolster/glove compartment
side chest wall	seatbelt
hip/abdomen	frame of car near windows
knee	roof of vehicle
leg	another occupant/animal
foot	other ______________________

Were any vehicle parts damaged in your car? If so, which ones?

❑ windshield ❑ seat frame ❑ knee bolster
❑ steering wheel ❑ side-rear window ❑ other: ___________________
❑ dash ❑ mirror ❑ other: ___________________

What were the road conditions at the time of the accident?

❑ dry ❑ wet ❑ icy ❑ other: ______________________________

Answer this section regardless of the type of crash; indicating those relevant to your case:

❑ Yes ❑ No Did any of the front or side structures, such as the dashboard, side door, or floorboard of your car dent inward during the crash?

❑ Yes ❑ No Did the side door touch your body during the crash?

❑ Yes ❑ No Was the door(s) of your vehicle damaged to the point where you couldn't open it?

❑ Yes ❑ No Have you noticed any visible bruising on your body ever since the accident? If yes, where? __________________________________

Have you been unable to work since the injury?

❑ Yes ❑ No If yes, how much did you miss work? ❑ partially ❑ completely

List the dates you were absent from work: From_____________ To_____________

Did you experience neck pain and/or back pain so severe that you were unable to get out of bed? If yes, how many hours after the accident did you develop this disabling level of pain?

❑ Yes; _______hours ❑ No

Answer this section if you were involved in a REAR-END COLLISION ONLY:

Does your vehicle have:

- ❑ movable / adjustable head restraints
- ❑ fixed, non-movable head restraints
- ❑ no headrests in my vehicle

Please indicate how your <u>head restraint</u> was positioned at the time of the crash:

- ❑ level with the top of your head
- ❑ midway height on the back of your head
- ❑ lower height on the back of your head
- ❑ located at the level of your neck
- ❑ located at the level of your shoulder blades (upper back) below neck

Estimate the distance between the back of your head & the front of the headrest.
Approximately __________ inches.

❑ Yes ❑ No Did your car separate away from the striking vehicle after the crash?
If yes, you are indicating that after the crash, your car was pushed away from the striking vehicle and your car did not stay attached.

What happened right after the accident?

❑ Yes ❑ No Did you go to the emergency room afterward?
If yes, Date:________________________ Time:_______________
Name of emergency room:__________________ City:__________

❑ Yes ❑ No Did you go to the emergency room in an ambulance?

❑ Yes ❑ No Did you or another person drive you to emergency?
Name of other person: ____________________________________

❑ Yes ❑ No Were you hospitalized after being seen in the emergency room?
If yes, how many days were you hospitalized? ________________

❑ Yes ❑ No Did the emergency room doctor take X-rays?
If yes, what regions were x-rays taken? (Check all that apply.)

❑ skull/face	❑ ribs/chest	❑ neck or middle back
❑ collar bone	❑ lower back	❑ shoulder, arm, or hand
❑ leg or foot	❑ pelvis/hip	❑ other:_____________

❑ Yes ❑ No Did the hospital or clinic take a MRI or CT of your body?
If yes, indicate the area of body tested.
❑ skull ❑ neck ❑ lower back, pelvis/hip ❑ other

❑ Yes ❑ No Did you have broken bones/fractures? If yes, where? __________

❑ Yes ❑ No Did you have a cast put on the fracture? If yes, where? _________

❑ Yes ❑ No Did you have any dislocations? If yes, where? ________________

❑ Yes ❑ No Did you have any cuts or lacerations? If yes, where? ___________

❑ Yes ❑ No Did you have any skin abrasions? If yes, where? ______________

❑ Yes ❑ No Did you need stitches for any cuts? If yes, where? _____________

What happened right after the accident? (continued)

❑ Yes ❑ No Did you have any visible bruises or lumps? Where? _____________

❑ Yes ❑ No Did the emergency room doctor give you any medications?
If yes, check all that apply and also write the name of medication:
❑ pain pills: ____
❑ muscle relaxants: ____
❑ other medications: _______________________________________

❑ Yes ❑ No Were you told you have a herniated disc? If yes, where? _________

❑ Yes ❑ No Were you given a neck brace to wear?

❑ Yes ❑ No Did you require any surgery after the accident?
If yes, what type? __________________________ Date:___________

❑ Yes ❑ No Were you hospitalized overnight? If yes, when? ________________

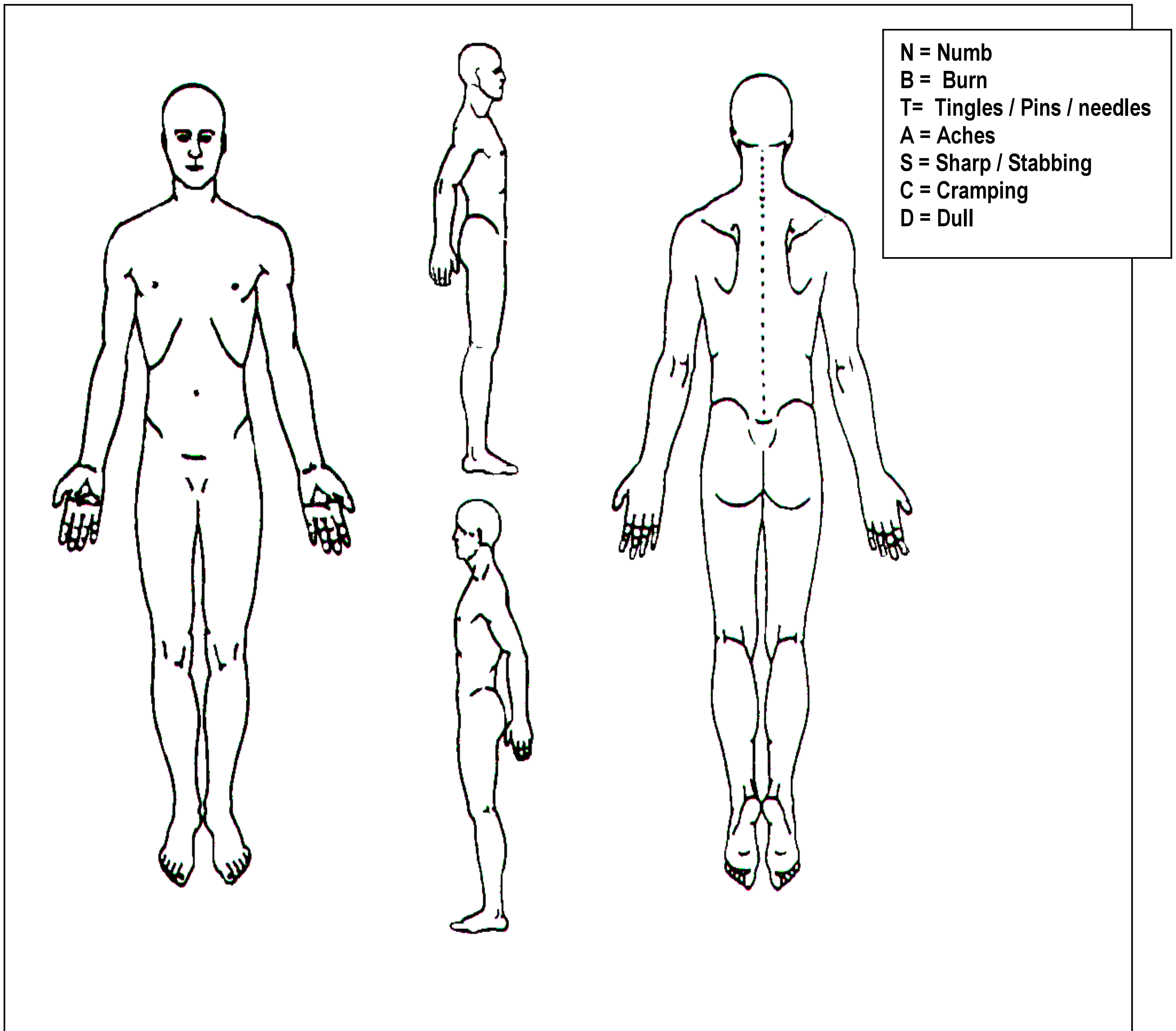
How soon after your injury did you first notice any pain or soreness?

❑ immediately / less than 30 minutes ❑ within ___ hours after the injury
❑ within ____ days after the injury

If you did not see a doctor for the first time within the two weeks, indicate why. (Check all that apply only if you had delay in seeing a doctor):

❑ no pain was noticed
❑ no appropriate schedule available
❑ work/home schedule conflicts
❑ thought pain would go away
❑ no transportation
❑ other: _________________________

Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.



Since the accident, On a scale between 0-10, please rate your pain levels below:

What is your **average** pain level? _____

What is your pain level at its **best**? _____

What is your pain level at its **worst**? _____

List and describe the doctors/therapists you have seen and all the tests done since the injury. Start with the emergency room (if you went), then the first doctor you saw after your injury. List in order all of the doctors, therapists, and massage therapists up to your last doctor/therapist seen. Check all that apply for each of the following:

Name of hospital/doctor/therapist/center: ____
Specialty: ____________________________________ Date first seen: _______________
Treatment type: ___________________ Treatment frequency: ______________________
Treatment duration: _____________________ Currently under treatment: ❑ Yes ❑ No
Any disability? ❑ Yes; describe: ____
❑ No
Special test(s): _________________________ Referred to: ________________________
Did treatment help? ❑ Yes ❑ No ❑ made condition worse
Notes: ____

Name of hospital/doctor/therapist/center: ____
Specialty: ____________________________________ Date first seen: _______________
Treatment type: ___________________ Treatment frequency: ______________________
Treatment duration: _____________________ Currently under treatment: ❑ Yes ❑ No
Any disability? ❑ Yes; describe: ____
❑ No
Special test(s): _________________________ Referred to: ________________________
Did treatment help? ❑ Yes ❑ No ❑ made condition worse
Notes: ____
____

Other Comments: ____

I certify that the above statements are true to the best of my knowledge.

____ __________________________

Patient Signature **Date**

Worker's Compensation Questionnaire

Patient Name: ____

Name of Employer: _________________________________ Phone #: ______________

Address of Employer: ____

What is the name of your personnel director? ___________________________________
Did you report the accident to your supervisor: ☐ Yes ☐ No
Did your supervisor submit a report to the insurance company? ☐ Yes ☐ No
Do you have a copy of the WC-1 form (accident report)? ☐ Yes ☐ No
Date of injury:____________________________ Time of injury: ________________
How many months/years have you been employed there? _________________________
Are you full time or part time? ☐ full time ☐ part time
How many hours do you work per day? ____
How many days do you work per week? ___________________________________
What is you job title? ____
Do you have an attorney for this claim ?______________________________________
Have you been treated for this condition by another doctor? Yes / No
If yes, who ________________________ When _____________________

What are you typical activities through-out your work day? (Check all that apply)

- ☐ sitting ________ hours
- ☐ standing ______ hours
- ☐ walking ________ hours
- ☐ computer work _______ hours
- ☐ reading ________ hours
- ☐ typing _________ hours
- ☐ driving ________ hours
- ☐ telephone _______ hours
- ☐ lifting frequently
- ☐ lifting occasionally
- ☐ heavy lifting > 50 lbs
- ☐ light lifting < 15-20 lbs
- ☐ pushing frequently
- ☐ pushing occasionally
- ☐ sorting papers
- ☐ 10-key typing
- ☐ running heavy machinery
- ☐ desk work

Draw a simple diagram to illustrate the scene of the accident (be sure to label each item in the diagram):

In your own words DESCRIBE IN DETAIL what happened:

____
____
____
____
____
____
____

☐ Yes ☐ No Did someone witness the accident? If yes, who ________________

If this is a slip and fall injury, answer these questions:

Was the floor/ground: ☐ wet ☐ dry ☐ slippery ☐ uneven/gravel ☐ muddy ☐ Other ______________________________

☐ Yes ☐ No Did you hold onto anything when you fell? If yes, what? ____

☐ Yes ☐ No When you landed, did you feel any sharp pain, tearing sensations?

☐ Yes ☐ No Did you feel your head whip backwards or forwards? If yes, which happened first? ____________________________________

☐ Yes ☐ No Was your head turned to one side (right or left) when you fell?

☐ Yes ☐ No Did you hit your head? If yes, on what? _____________________

☐ Yes ☐ No Did you lose consciousness? If yes, how long?________________

☐ Yes ☐ No Were you able to stand up without assistance?

How long did it take for you to feel ready to stand up? __________________________

If this is a lifting injury answer these questions (check all that apply):

☐ Yes ☐ No Were you pushing or pulling? If yes, describe ____

☐ Yes ☐ No Were you bending forward and twisted to the left or right while lifting the box/luggage etc.? If yes, describe ____

☐ Yes ☐ No Did you hear a popping sound or clicking sound coming from your neck or back at the time of the injury? If yes, describe ____

☐ Yes ☐ No Did you feel a pull or strain like sensation at the time of the injury?

What Happened Right After The Accident? (Check all that apply)

Did you leave the job? ☐ Yes ☐ No
How many days have you missed? _____________ Dates:_______________________

How soon after your injury did you first notice any pain-soreness after your injury?
☐ immediately / less than 30 minutes
☐ within ___________ hours after the injury
☐ within ___________ days after the injury

If you did not see a doctor for the first time within the two weeks, indicate why (check all that apply only if you had delay in seeing a doctor):

☐ no pain was noticed	☐ no appropriate schedule available	☐ thought pain would go away
☐ no transportation	☐ work/home schedule conflicts	☐ other

Have you been treated for this condition by another physician? ☐ Yes ☐ No
If yes, who did you see? _____________________________ Date: ___________
Were any drugs prescribes? ☐ Yes ☐ No
If yes, what drugs and how much are you taking? ____________________________
Did it help? ☐ Yes ☐ No ☐ Made it worse
Were X-rays taken? ☐ Yes ☐ No

Please circle all of the following symptoms you are currently experiencing as a result of the injuries sustained at work (circle all that apply):

Sharp pain	Dull pain	Ache
Tingling	Numbness	Stabbing Pain
Headaches	Nausea	Diarrhea
Neck aches / pains	Dizziness	Feet cold
Neck stiffness	Loss of memory	Hands cold
Upper back aches/pains	Mood swings	Constipation
Lower back aches/pains	Stressed	Cold sweats
Chest pains	Irritability	Fever
Pain between the shoulder blades	Anxiety	Thigh pain
Numbness / tingling into arms	Head seems heavy	
Numbness / tingling into hand	Shortness of breath	
Numbness / tingling into fingers	Fatigue	
Numbness / tingling into legs	Ears ringing	
Numbness / tingling into feet	Ears burning	
Numbness / tingling into toes	Loss of balance	
Weakness into the arms	Fainting	
Weakness into the legs	Loss of smell	
Difficulty getting to sleep	Loss of taste	

Answer this section if you went to emergency for injuries (check all that apply):

Give the date and time you went to emergency:______________________________
Name of emergency room: ___________________________________ City________

- ☐ Yes ☐ No Did you go the emergency room in an ambulance?
- ☐ Yes ☐ No Did you or another person drive you to emergency?
  Name of other person:___________________________________
- ☐ Yes ☐ No Were you hospitalized after being seen in the Emergency room?
  If yes, how many days:__________________________________
- ☐ Yes ☐ No Did the emergency room doctor take X-rays?
  Check what regions x-rays were taken
  ☐ skull / face ☐ ribs / chest
  ☐ neck or middle back ☐ collar bone
  ☐ low back or pelvis/hip ☐ shoulder, arm, or hand
  ☐ leg or foot ☐ other
- ☐ Yes ☐ No Did the hospital or clinic take MRI or CT of your body? If yes, indicate area of body tested.
  ☐ skull ☐ neck ☐ lower back or hip/pelvis ☐ other
- ☐ Yes ☐ No Did you have any broken bones/fractures? If yes, where _______
- ☐ Yes ☐ No Did you have a cast put on the fracture? Where ______________
- ☐ Yes ☐ No Did you have any dislocations? Where _____________________
- ☐ Yes ☐ No Did you have any cuts or lacerations? Where _______________
- ☐ Yes ☐ No Did you have any skin abrasions? Where ___________________
- ☐ Yes ☐ No Did you need stitches for any cuts? Where _________________
- ☐ Yes ☐ No Did you have any visible bruises or lumps? Where ___________
- ☐ Yes ☐ No Did the emergency room doctor give you medications?
  ☐ Yes ☐ No Pain pills ________________________________
  ☐ Yes ☐ No Muscle relaxants _______________________
  Other Medications:___________________________________
- ☐ Yes ☐ No Were you told you have a herniated disc? If yes, where_______
- ☐ Yes ☐ No Were you given a neck brace to wear?
- ☐ Yes ☐ No Did you require any surgery after the accident?
  If yes, what type and date _______________________________
- ☐ Yes ☐ No Were you hospitalized overnight? When?___________________

List and describe *other* doctors (does not need to include this clinic) / therapists seen and all tests done since the injury. Start with the emergency room (if you went), the 1st doctor you saw after your injury and list in order all doctors, therapists, massage therapists up to your last doctor/therapist seen and check all that apply for each:

Name of hospital/doctor/therapist/center: ____________________________________
Specialty:_________________________________ Date first seen: ________________
Treatment type: ____________________Treatment Frequency: __________________
Treatment duration: _____________________ Currently under treatment: ◻ Yes ◻ No
Any disability? ◻ Yes ◻ No If yes, describe:
____
Special test(s):____________________________ Referred to: ___________________
Did treatment help? ◻ Yes ◻ No ◻ made condition worse
Notes:____

Name of hospital/doctor/therapist/center: ____________________________________
Specialty:_________________________________ Date first seen: ________________
Treatment type: ____________________Treatment Frequency: __________________
Treatment duration: _____________________ Currently under treatment: ◻ Yes ◻ No
Any disability? ◻ Yes ◻ No If yes, describe:
____
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Notes: ____

Name of hospital/doctor/therapist/center: ____________________________________
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Treatment duration: _____________________ Currently under treatment: ◻ Yes ◻ No
Any disability? ◻ Yes ◻ No If yes, describe:
____
Special test(s):____________________________ Referred to: ___________________
Did treatment help? ◻ Yes ◻ No ◻ made condition worse
Notes: ____

I certify that the above information is true to the best of my knowledge.

____
Patient Name:

____ _________________
Patient Signature Date