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Name of patient:____Date:________________________

ACCIDENT QUESTIONNAIRE

(Please spend at least one hour filling in all questionnaires –VERY IMPORTANT FOR THE CORRECT TREATMENT OF YOUR DIAGNOSIS)

DATE OF BIRTH: ____
DATE OF CONSULT: ____
DATE OF ACCIDENT: ____

LIST NAMES OF TREATING DOCTORS:

1.	**3.**	**5.**
2.	**4.**	**6.**

Were you involved in an automobile accident? ________ (yes or no). If you were involved in an automobile accident please respond to all questions.

If this is not an automobile accident answer "N/A" to questions #1-18 and then respond to questions #19 and the remainder of the questionnaire.

1. If automobile accident, type and year of vehicle patient in:	
2. If automobile accident, type and year of other vehicle involved:	
3. Location of accident: **Time of Day:** **Wet OR Dry:**	
4. If automobile accident, where was your vehicle struck – rear, front, left side, or right side?	
5. If automobile accident, where were you looking at impact – straight ahead, left, or right? **Were you the driver or passenger? __________** **How fast were you going? __________**	
6. If automobile accident: **a. Was your seatbelt on and properly attached?__________** **b. Was your head rest up? __________** **c. Did your seat stay upright? __________**	
7. If automobile accident, did you hit your head on the headrest or	

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anything else?	

Name of patient:____Date:_________________________

ACCIDENT QUESTIONNAIRE (continued)

8. If automobile accident, did the airbag deploy on your vehicle? **a. Did the other vehicle's airbag deploy?** **b. Were you injured by the airbag?** **c. If so, how were you injured by airbag?**	
9. If automobile accident, was your automobile drivable?	
10. If automobile accident, what was the dollar amount of damage to your vehicle?	
11. If automobile accident, did you see the other vehicle coming?	
12. If automobile accident, did you see the other driver's face before impact?	
13. If automobile accident, did you hear the squeal of the brakes?	
14. If automobile accident, when your automobile was hit how far were you pushed and in what direction?	
15. If automobile accident, did you strike anything else after you were pushed?	
16. If automobile accident, was there a second collision with a curb or another automobile?	
17. If automobile accident, were you conscious the whole time? **If not, how long were you unconscious?**	
18. If automobile accident, were you able to get out of your	

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automobile on your own? ________	
19. If not an automobile accident, please describe your accident in detail – everything you remember – when, where, how. (Please use the next page for more room)	

Name of patient:____Date:_________________________

ACCIDENT QUESTIONNAIRE (continued)

19.	
20. Were you conscious the whole time? __________ **If not, how long were you unconscious? __________**	
21. Were you steady on your feet after the accident?	
22. Did EMS come to the scene of your accident? __________ **Did you use EMS? __________** **Do you remember EMS? __________**	
23. Did you go to an emergency room? __________ **If so, where? ______________________________** **If so, when? ____** **If so, how did you get there?** **____** **If so, do you remember the emergency room? __________** **If so, how long were you in the emergency room?** **____**	
24. Were you admitted to the hospital? __________ **If so, which hospital?** **____** **If so, for how long? ____**	

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25. Have you had CTs? __________ **If so, where? ____** **If so, when? ____** **If so, list parts of body (brain, cervical spine, lumbar spine, etc.)** **What did they show? ____** **PLEASE BRING THE CT DISC/S, FOR REVIEW AT YOUR APPOINTMENT.**	

Name of patient:____Date:________________________

ACCIDENT QUESTIONNAIRE (continued)

26. Have you had any MRIs? __________ **If so, where? ____** **If so, when? ____** **If so, list parts of body (brain, cervical spine, lumbar spine, etc.)** **What did they show?** **PLEASE BRING THE MRI DISC/S, FOR REVIEW AT YOUR APPOINTMENT.**	
27. Did you take any therapy or treatments? __________ **With whom? ____** **How many times? ____** **Did it help? ____**	
28. Were you on medication? __________ **If so, please list type and dosage:** **Did the medication help?**	
29. Do you have neck pain? _________ When did it start? _________ **Do you still have neck pain?__________** **If so, please fill out the neck questionnaire from our website.**	
30. Do you have headaches? _______When did they start? ________ **Do you still have headaches?___________** **If so, please fill out the headaches questionnaire from our website.**	
31. Do you have low back pain? __________ **When did it start? __________Do you still have LBP?__________**	

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If so, please fill out the back pain questionnaire.	
32. Did you strike your head in the accident? __________ **If yes, on what? ______________________________**	
33. Did you have a concussion? _______Were you dazed? ________ **If yes, please fill out the concussion questionnaire.**	
34. Did you have any bruises or cuts on your body or head from the accident? **If yes, describe where.**	

Name of patient:____Date:________________________

ACCIDENT QUESTIONNAIRE (continued)

35. Did you have dizziness? __________ **When did it start? __________** **Are you still dizzy?__________________** **If yes, please fill out the long and short dizziness questionnaire both.**	
36. Are you getting better or worse? __________ **If worse, please describe how and why.**	
37. Did you miss work? __________ **If so, how long? ____________________** **Why?**	
38. Do you still have pain or difficulty performing any of the following activities as a result of your accident? ________ ****Please circle all that apply and rate the severity from 1-3.**** **MILD-1 MODERATE-2 SEVERE-3_______** **Lifting / Reading / Concentrating** **Working / Driving / Sleeping** **Recreation / Walking / Sitting** **Standing / Social life / Job performance** **Exercise / Sexual activity**	

NOTE: You will undergo a thorough neurological examination by a very experienced neurologist. You must do your best on each testing during the examination. The doctor will know and will comment in his letter that you did or did not try your best on the examination.

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If there is symptom magnification or exaggeration of symptoms, the neurologist will know and will comment on it in the letter, which is part of the public record.

NOTA: Usted sera sometido a un examen neurológico minucioso por un neurólogo muy experimentado. Usted debe hacer su mejor en cada prueba durante el examen. El médico sabrá y comentará en su carta que usted hizo o no hizo lo mejor que pudo en el examen.
Si hay una amplificación de los síntomas o exageración de los síntomas, el neurólogo lo va saber y lo comentará en la carta, que es parte del registro público.

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