Patient Questionnaire – Work-Related-Auto-Accident

Patient Name: _____ Today's Date: ____/____/____

Basic Information about the Accident:

Date Accident Occurred or Started: ____/____/____
Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place:

_____
_____
_____
_____

Describe the condition or symptoms caused by the Accident:

_____
_____
_____
_____

Auto-Accident Specific Information:

Were you the: □ Driver □ Passenger □ Pedestrian
Automobile you were in: Year _____ Make _____ Model _____
Damage to your car: □ Front □ Rear □ Pedestrian □ Driver Side □ Passenger Side □ Bumper □ Fender
Damage Amount Estimate: $_____ : □ Minor □ Major □ Totaled
Other Automobile: Year _____ Make _____ Model _____
Damage to other car: □ Front □ Rear □ Pedestrian □ Driver Side □ Passenger Side □ Bumper □ Fender
□ Minor □ Major □ Totaled
Where did the accident happen? Street Names: _____ City/State _____
Was it? □ Controlled Intersection □ Uncontrolled □ Not Intersection
Was there a traffic light? □ None □ Green □ Red □ Turn Arrow □ Stop Sign
Were you: □ Slowly Moving □ Moving □ Stopped
Weather Conditions: □ Sunny □ Rainy □ Cloudy
Street Surface: □ Dry □ Wet □ Slick □ Icy □ Pavement □ Other _____
Type of Impact: □ Rear end □ Front □ Side Impact □ Roll Over
Brakes on Impact: □ Locked Tight □ Loosely Applied □ Foot not on brake
How far did your car move? □ Did not move □ Moved 1-5 ft □ Moved 6-10 ft □ Moved over 10 ft
Where were you seated in the vehicle: _____ Wearing Seat belt? □ Yes □ No
Shoulder harness: □ Yes □ No Headrest: □ Yes □ No Headrest Position: □ Up □ Down
Is the car equipped with airbags? □ Yes □ No Did they deploy? □ Yes □ No
Did you see the impact coming? □ Yes □ No Did you brace yourself for impact? □ Yes □ No
On impact, your head was looking: □ Ahead □ Behind □ Up □ Down □ To the Right □ To the Left

On impact were you: □ Thrown forward □ Thrown backwards □ Thrown sideways □ Other _____

Did your body hit anything inside the car? □ Yes □ No Body Part: _____

What did it hit? _____

Head trauma? □ Yes □ No Loss of Consciousness? □ Yes □ No For how long? _____

Do you remember the accident happening? □ Yes □ No

Hospital? □ Yes □ No Name of hospital: _____ How long there? _____

Taken by ambulance? □ Yes □ No

X-rays taken? □ Yes □ No X-ray areas: □ Neck □ Mid-back □ Low-back □ Other X-rays _____

Medication Given? □ Yes □ No RX: _____

Other instruction: _____ Follow-up: _____

Work-Accident Specific Information:

Check all that apply:

□ Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?
□ Did the accident occur during your normal working hours?
□ Did you report the accident to your Employer?
□ Is your Employer covered by Workers' Compensation Insurance under state law?
□ Has your Employer prepared an initial written report?
□ Does the Employer's Report describe the condition or symptoms you are experiencing?
□ Has a claim number been issued for this accident?
□ Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?