Elite Performance And Therapy

Accident/Injury Questionnaire

Patient: _____ **#:** _____
Today's Date: ____/____/_____

A. DATE AND TIME OF ACCIDENT/INJURY
Date: ____/____/_____ Time: ____:____ am/pm

B. DESCRIPTION OF ACCIDENT/INJURY
☐Automobile Crash ☐Workmen's Compensation
Other: ☐Accident ☐Injury _____

C. DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED
_____
_____
_____
_____
_____
_____
_____

D. DETAILS OF AUTOMOBILE ACCIDENT

1. Your Vehicle

a) Type: _____

b) Vehicle Size
☐Compact ☐Mid-Size ☐Full-Size ☐Other: _____

c) What Was Your Location In The Vehicle?
☐Driver ☐Front Passenger **Rear**: ☐Left ☐Middle ☐Right

d) What Damage Did The Vehicle You Were In Sustain?
☐Minimal ☐Moderate ☐Extensive ☐Totaled ☐Unsure

2. Other Vehicle

a) Type: _____

b) Vehicle Size
☐Compact ☐Mid-Size ☐Full-Size ☐Other: _____

c) How Did This Vehicle Strike The Vehicle You Were In?
☐Heads On ☐From Right ☐From Left ☐Rear Ended
☐Sideswiped On Left ☐Sideswiped On Right ☐Other: _____

d) **What Damage Did The Other Vehicle Sustain?**
☐Minimal ☐Moderate ☐Extensive ☐Totaled ☐Unsure

3. Describe Any Other Vehicle(s) To Strike The Vehicle You Were In
_____
_____
_____
_____

4. Were Traffic Citations Issued As A Result Of The Accident?
☐No ☐Driver Of Your Vehicle ☐Driver Of Other Vehicle ☐You ☐Unsure

5. **Conditions At The Time Of Accident?**
   a) **Timing:** ☐Daylight ☐Night ☐Dawn ☐Dusk ☐Other: _____
   b) **Road:** ☐Dry ☐Wet ☐Snow Covered ☐Icy ☐Other: _____
   c) **Visibility:** ☐Good ☐Fair ☐Poor ☐Other: _____
6. **At Moment Of Impact**
   a) **Were You Prepared For The Accident?**
      ☐No ☐Yes
   b) **Were You Wearing A Seatbelt?**
      ☐No ☐Yes If Yes: ☐Shoulder Belt ☐Shoulder-Lap Belt ☐Lap Belt
   c) **Was The Vehicle Equipped With Headrests?**
      ☐No ☐Yes If Yes, Location: ☐Low ☐Middle ☐High ☐Unknown
   d) **Did Airbags Deploy?**
      ☐No ☐Yes
7. **Your Body Positioning**
   a) **What Was Your Body Position At Impact?**
      ☐Straight ☐Slouched Forward **Rotated**: ☐Left ☐Right
      ☐Don't Recall ☐Other: _____
   b) **What Direction Was Your Body Thrown?**
      ☐Forward/Backwards ☐Sideways ☐Across Vehicle
      ☐Outside Vehicle ☐Don't Recall ☐Other: _____
8. **Your Head/Neck Positioning**
   a) **What Was Your Head/Neck Position At Impact?**
      ☐Straight ☐Tilted Forward **Rotated**: ☐Left ☐Right
      ☐Don't Recall ☐Other: _____
   b) **Through What Motion Were Your Head/Neck Thrown?**
      ☐Forward/Backwards ☐Sideways ☐Don't Recall
      ☐Other: _____
9. **Result Of Impact**
   a) **Did The Force Of Impact Cause Your Head/Neck To Strike Anything?**
      ☐No ☐Yes If Yes, Then What: _____
   b) **Did The Force Of Impact Cause Any Other Part OF Your Body To Strike Anything?**
      ☐No ☐Yes If Yes, Then What: _____

E. IMMEDIATELY AFTER THE ACCIDENT

1. **Did You Lose Consciousness?**
   ☐Yes ☐No ☐Don't Know
2. **How Did You Feel?**
   ☐Confused ☐Dazed ☐Dizzy ☐Nervous ☐Weak ☐Other: _____
3. **Where Did You Immediately Feel Pain?**
   ☐Head ☐Neck ☐Upper Back ☐Mid Back ☐Low Back ☐Arms ☐Legs
   ☐Other: _____

4. **Did You Receive Emergency Care?**
   ☐No ☐Yes If Yes, Then Describe Care: _____
5. **Destination After Accident/Injury**
   ☐Hospital ☐Home ☐Work ☐School ☐Other: _____

F. HOSPITAL VISIT AFTER THE ACCIDENT/INJURY

1. **When Did You Go?**
   ☐Immediately ☐Later That Day ☐Next Day ☐Days Later
   ☐Other: _____
2. **Were X-rays Taken?**
   ☐Yes ☐No
3. **Was A CAT Scan Performed?**
   ☐Yes ☐No
4. **Was An MRI Performed?**
   ☐Yes ☐No
5. **What Was The Diagnosis(es) Given At The Hospital?**

_____
_____
_____
_____

6. **What Treatment(s) Was/Were Given At The Hospital?**

_____
_____
_____

7. **What Recommendations Were Made?**

_____
_____
_____

G. FOLLOWING THE ACCIDENT/INJURY

1. **What, If Any, Additional Symptoms Developed?**

_____
_____
_____
_____

2. **How Much Later Did Additional Symptoms Develop?**
   ☐Immediately ☐Hours ☐That Evening ☐Next Morning ☐Days ☐Week
   ☐Month ☐Other: _____

Elite Performance And Therapy

Accident/Injury Questionnaire

3. Since Your Accident/Injury Have You Suffered From?

☐Blurred Vision ☐Double Vision ☐Reduced Vision ☐Impaired Hearing
☐Ringing In Ears ☐Chest Pain ☐Difficulty Breathing ☐Palpitations
☐Constipation ☐Diarrhea ☐Nausea ☐Vomiting ☐Frequent Urination
☐Inability To Hold Urine ☐Painful Urination ☐Anxiety ☐Depression
☐Mood Swings ☐Nervousness ☐Poor Memory ☐Tension ☐Convulsions
☐Dizziness ☐Headaches ☐Fainting ☐Loss Of Balance ☐Fatigue
☐Restlessness ☐Insomnia ☐Light Sensitivity ☐Reduced Appetite
☐Weakness ☐Weight Gain ☐Weight Loss ☐Other: _____

4. Has The Accident/Injury Restricted Your Activities?

☐No ☐Yes If Yes, Describe: _____
_____
_____
_____

5. Have You Missed Work Due To This Accident/Injury?

☐Missed No Work ☐Limited Work Activity
☐Missed Work From: ____/____/_____ to ____/____/_____

6. Did You Self Treat Your Symptoms?

☐No ☐Yes If Yes, Then How Or With What: _____
_____
_____

H. INSURANCE/ATTORNEY INFORMATION

1. Have You Contacted An Insurance Adjuster Or Representative Regarding This Claim?

☐No ☐Yes If Yes, Company: _____
Adjuster: _____ Claim #: _____

2. Have You Engaged Services Of An Attorney?

☐No ☐Yes If Yes, Attorney: _____
Address: _____
City: _____ State: ____ ZIP: _____
Phone: (____) _____-_____

3. Have You Filed An Accident/Injury Report?

☐No ☐Yes

4. Have You Filed For Insurance Benefits?

☐No ☐Yes

_____ ____/____/_____
Patient Or Guardian's Signature Date