

**History of Injury from Motor Vehicle Crash**

Your Name \_\_\_\_\_ Date \_\_\_\_\_ Injury Date \_\_\_\_\_

Driver  Passenger ( Front seat  Rear seat  R  L) Anyone else in your vehicle with you  Y  N

What area of your car was struck:  Rear  Front  Driver Side  Passenger Side

Front Right Oblique  Front Left Oblique  Rear Right Oblique  Rear Left Oblique

Road conditions at time of crash  Dry  Wet  Ice  Sandy

What was the size, make, model and year of the vehicle that struck your vehicle \_\_\_\_\_

What is the make, model and year of your vehicle \_\_\_\_\_

What approximate speed was the other vehicle traveling when it hit you \_\_\_\_\_

At time of impact was your vehicle moving (at what speed \_\_\_\_\_)  straight  turning  right  left

stopped - did you have your foot on the break  Y  N

Were your tires in the  straight ahead position or  turned to the  right or  left and to what degree \_\_\_\_\_

After the impact was your vehicle pushed  forward  backward  straight  spun to the  right  left

Did your car strike anything else \_\_\_\_\_ Did your vehicle need to be towed?  Y  N

Car equipped with  shoulder/lap belt harness  lap harness only  shoulder harness only

and was  on  off;  did or  failed to restrain you.

Car equipped with headrests that were positioned  correctly  incorrectly \_\_\_\_\_

Headrest was  inches above and away from the top of your head \_\_\_\_\_

inches below and away from the top of your head \_\_\_\_\_

Your seat  was  was not in the full upright position  Seat back broke upon impact

Angle of the back of your seat was more than 90 degrees or slanting back position  Y  N

Vehicle equipped with airbag  Y  N

Air bag  did  didn't deploy causing injury to \_\_\_\_\_

Patient's head was  Straight ahead  Up degrees \_\_\_\_\_  Down degrees \_\_\_\_\_

Right degrees \_\_\_\_\_  Left degrees \_\_\_\_\_  Combination \_\_\_\_\_

Your body was out of position (explain) \_\_\_\_\_

You  did  did not see accident coming  did  did not have time to brace for impact

You  cannot remember  did not  did strike body part  head  face  shoulder ( R  L)  knee ( R  L)  chest  hip

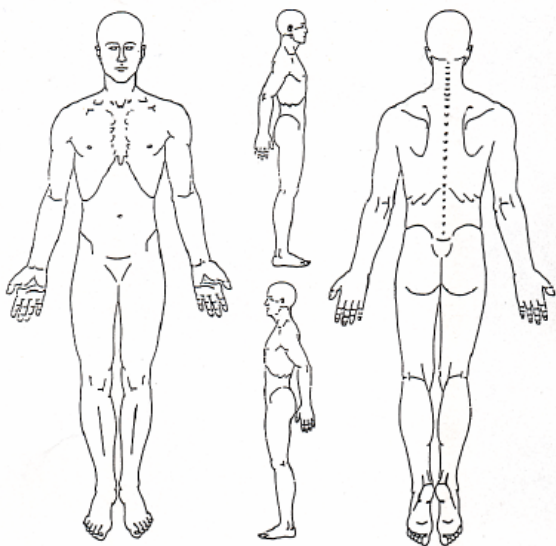
( R  L)  ankle ( R  L)  foot ( R  L)  wrist ( R  L)  hand ( R  L)  elbow ( R  L)

With  steering wheel  door  dashboard  windshield  airbag  rearview mirror  other

You  did  did not lose consciousness \_\_\_\_\_

You  were  were not cut or bleeding \_\_\_\_\_

did  did not have broken bones \_\_\_\_\_



Scale 1 to 10 – 10 being the worst pain ever felt

**Prior to This Injury**

Previous automobile crashes Y N See Attachment

Any other accidents in the past Y N \_\_\_\_\_

Have you ever had cancer? Y N \_\_\_\_\_

Does your pain ever wake from a sound sleep? Y N

Are you losing weight now without trying? Y N

Are you coughing up blood or noticing it in your stools or urine? Y N

Have you had any loss of bladder or bowel control? Y N

Have you lost consciousness recently? Y N \_\_\_\_\_

Concerning your vision, have you had double vision or problems with seeing recently? Y N

Are you having any problem with swallowing? Y N

Are you seeing any other doctor now for any reason? Y N \_\_\_\_\_

Do you have any other symptoms or health problems? Y N \_\_\_\_\_

Are you taking any medications or over-the-counter drugs now? Y N \_\_\_\_\_

Have you been sick or had an infection lately? Y N \_\_\_\_\_

Is there any chance that you are pregnant now? Y N

Have you recently been injured prior to this injury? Y N \_\_\_\_\_

Sleep restful restless 6-8 hrs 8-10 hrs \_\_\_\_\_

Job description \_\_\_\_\_

School activities \_\_\_\_\_

Daily living \_\_\_\_\_

Drug use: smoker \_\_\_\_\_ alcohol  
pain killers \_\_\_\_\_ muscle relaxants  
other \_\_\_\_\_

Hobbies \_\_\_\_\_

**Present Time**

N/A Anyone else in your car injured Y N \_\_\_\_\_

When did your symptoms first appear \_\_\_\_\_

Has your symptoms changed since the time of the accident until now (*are the symptoms in a different location, intensity or frequency*) \_\_\_\_\_

Did you go to the hospital Y N How did you get there \_\_\_\_\_

How long was the hospital stay \_\_\_\_\_

What was done at the hospital \_\_\_\_\_

What were the results \_\_\_\_\_

How did you leave the hospital \_\_\_\_\_

Who drove \_\_\_\_\_

Has there been any visual disturbances Y N \_\_\_\_\_

Ringing in the ears Y N

Memory loss Y N \_\_\_\_\_

Emotional changes Y N \_\_\_\_\_

**At the time of the present accident did you feel:**

Y N Dazed                      Y N Disoriented                      Y N Confused

**Post-Concussion Syndrome-Symptoms**

- |  |   |  |
|--|---|--|
| 1. <input type="checkbox"/> Y <input type="checkbox"/> N Light Headedness                | 6. <input type="checkbox"/> Y <input type="checkbox"/> N Phonophobia (affected by sounds) | 11. <input type="checkbox"/> Y <input type="checkbox"/> N Forgetfulness                              |
| 2. <input type="checkbox"/> Y <input type="checkbox"/> N Vertigo/dizziness               | 7. <input type="checkbox"/> Y <input type="checkbox"/> N Tinnitus (ringing in the ears)   | 12. <input type="checkbox"/> Y <input type="checkbox"/> N Impaired logical thought                   |
| 3. <input type="checkbox"/> Y <input type="checkbox"/> N Neck Pain                       | 8. <input type="checkbox"/> Y <input type="checkbox"/> N Impaired memory                  | 13. <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty with new or abstracted concepts |
| 4. <input type="checkbox"/> Y <input type="checkbox"/> N Headache                        | 9. <input type="checkbox"/> Y <input type="checkbox"/> N Easy distractibility             | 14. <input type="checkbox"/> Y <input type="checkbox"/> N Insomnia (difficulty in sleeping)          |
| 5. <input type="checkbox"/> Y <input type="checkbox"/> N Photophobia (affected by light) | 10. <input type="checkbox"/> Y <input type="checkbox"/> N Impaired comprehension          | 15. <input type="checkbox"/> Y <input type="checkbox"/> N Easy fatigability                          |
| 16. <input type="checkbox"/> Y <input type="checkbox"/> N Apathy                         | 17. <input type="checkbox"/> Y <input type="checkbox"/> N Outbursts of anger              | 18. <input type="checkbox"/> Y <input type="checkbox"/> N Mood swings                                |
| 19. <input type="checkbox"/> Y <input type="checkbox"/> N Depression                     | 20. <input type="checkbox"/> Y <input type="checkbox"/> N Loss of libido                  | 21. <input type="checkbox"/> Y <input type="checkbox"/> N Personality change                         |