New England Spine & Disc Center, P.C

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Auto Accident Questionnaire

1) General Information

Name: _____

Date of Birth: _____

SSN (optional): _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____

How did you hear about our clinic? _____

Who is Attorney at this time? _____

History of Accident Information

1) What is/ was the date you were injured?

_____

2) How many vehicles were involved in the accident?

_____

3) Where was the car damaged? SLIGHT MILD MODERATE SERVE (please describe)

_____

_____

4) What city and State did the accident occur?

_____

_____

5) What areas in the car were damaged in the accident?

_____

6) Were you, Driver, Passenger, Front, or Back

_____

7) Were you aware of the accident?

_____

8) What type and model of the car you were in?

_____

9) What type and model of the car that stuck you?

_____

10) How fast were you moving at the time of impact _____ mph

11) How fast was the other vehicle moving at the time of impact? _____mph

12) Did you lose consciousness at the time of impact? Yes or No

13) What objects did you strike inside the car at the time of impact?

_____

_____

14) What type of headrest was in your car, Movable Fixed / Non Moveable Fixed/ No Headrest?

_____

15) Was the headrest positioned low, middle or high on your head?

_____

16) Where you wearing a seatbelt at the time of the accident? Yes or No

17) Did the air bags deploy? Yes or No

18) What hospital did you go to after the accident? How did you get there?

_____

19) What areas were x-rayed at the hospital?

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20) Where you prescribed medication or muscle relaxers at the time?

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21) What medications do you take normally? Please

22a.) Do you have a positive family history of disease? Yes or No If so, please list.

22b.) Do you have a positive history of disease?

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23) Are you a smoker? Yes or No

24) Are you diabetic? Yes or No

25) WHAT ARE YOUR INJURIES FROM THE ACCIDENT? Please list all areas with a pain scale 1-10 ("1" being no pain, "10" being excruciating pain). Ex: Neck, Back, Shoulder Etc.

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26) What makes your pain feel better?

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27) What makes your pain feel worse?

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28) Are you employed? Yes or No if so, what is your type of employment?

29) Have your symptoms affected your social or work activates? Yes or No if so, please describe.

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30) What is your height? _____ Weight? _____

31) How would you rate your overall health? EXCELLENT – VERY GOOD – GOOD -FAIR – POOR

32) Please list any SURGERIES you have had and the YEAR you had the procedures.

_____

_____

33) Have you had any previous accidents? Yes or No If so, please list year of accidents.

_____

_____

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT: _____

TRANSLATOR: _____