



impactclinic

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impactclinic.com

Accident History Questionnaire

Date _____

First Name: _____ Last Name: _____ Initial: _____

PERSONAL INJURY PATIENT HISTORY

1. Date of accident: _____
2. Time: _____ AM/PM
3. Driver of car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year and model of the car: _____
7. What was the approximate damage done to your car? \$ _____
 - 7a. What was the other vehicle make? Damage? _____ \$ _____
 - 7b. Have you had a professional estimate?
 - Yes No How much \$ _____
8. Visibility at time of accident:
 - Poor Fair Good Other _____
9. Road conditions at time of accident:
 - Icy Rainy Wet Clear
 - Dark Other _____
10. Where was your car struck? Right Left
 - Rear Front Side Other _____
11. Type of accident: Head-on collision
 - Broad-side collision Front impact
 - Rear-end collision Non-collision
12. Describe in your own words what happened to you upon impact: _____

13. Did you see the accident coming? Yes No
14. Did you brace for impact? Yes No
15. Were seatbelts worn? Yes No
16. Were shoulder harnesses worn? Yes No
17. Does your car have headrests? Yes No
18. If yes, what was the position of those headrests compared to your head before the accident?
 - Top of headrest even with bottom of head
 - Top of headrest even with top of head
 - Top of headrest even with middle of head
19. Was your car braking? Yes No
20. Was your car moving at the time of the accident?
 - Yes No
21. If yes, how fast would you estimate you were going? _____ mph
22. How fast do you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
 - Head turned left/right
 - Body straight in sitting position
 - Head looking back
 - Body rotated left/right
 - Head straight forward
 - Other _____
24. At the time of accident, recall what parts of your head or body hit parts of the inside of your car: _____

25. As a result of the accident you were:
 - Rendered unconscious
 - Dazed, circumstances vague
 - Other _____
26. Could you move all parts of your body?
 - Yes No
27. If no, what parts couldn't you move and why? _____

28. Were you able to get out of the car and walk out of the car unaided? Yes No
29. If no, why not? _____

30. Did you get bleeding cuts or bruises?
 - Yes No
31. If yes, what bleeding cuts did you get from this accident? _____

32. If yes, what bruises did you get from this accident? _____

33. Please, describe how you felt:
 - Immediately after the accident _____

 - Later that day _____

34. Check symptoms apparent since the accident:
- | | |
|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck pain/Stiffness |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Eyes light sensitive |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Numb fingers | <input type="checkbox"/> Numb toes |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Ring/buzz in ears |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Other _____ | |
35. Occupation: _____
36. Employer: _____
37. Have you missed time from work? Yes No
38. If yes, full time off work: _____ to _____
39. If yes, part time off work: _____ to _____
40. Did you seek medical help immediately after the accident?
 Yes No
41. If yes, how did you get there? _____
42. Doctor #1, Name: _____
43. First visit date: _____
44. Were you examined? Yes No
45. Were X-Rays taken? Yes No

46. Did you receive treatment? Yes No
47. If yes, what kind of treatment did you receive? _____

48. What benefits did you receive from the treatment? _____

49. Date of last treatment: _____
50. Doctor #2, Name: _____
51. First visit date: _____
52. Were you examined? Yes No
53. Were X-Rays taken? Yes No
54. Did you receive treatment? Yes No
55. If yes, what kind of treatment did you receive? _____

56. What benefits did you receive from the treatment? _____

57. Date of last treatment: _____
58. Do you have an attorney on this claim? Yes No
59. If yes, who? _____
Address _____
City, State, Zip Code _____
60. Illustrate below how the accident happened:

PAST MEDICAL HISTORY

Place an (X) if it applies and describe.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> None related to current complaints | <input type="checkbox"/> Hospital or Operation | <input type="checkbox"/> Auto Accident | <input type="checkbox"/> Work accident |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Other (describe) _____ | | |

FAMILY HISTORY

Place an (X) if it applies and describe.

- | | | | | |
|---------------------------------------|---|--|---|-----------------------------------|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spinal disorder | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Other (list) _____ | |

PERSONAL HISTORY

Place an (X) if it applies and describe.

- | | | | | | |
|---------------------------------|----------------------------------|-----------------------------------|------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated | <input type="checkbox"/> Widowed | Employed Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Number of children _____ | | Number of children at home _____ | | | |
| Medications _____ | | Disease (describe) _____ | | | |

INSURANCE INFORMATION

Place an (X) if it applies and describe.

- | | |
|--|--|
| Was a police report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have a copy? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Driver of other vehicle: _____ | Their insurance company: _____ |
| Policy number: _____ | Agent or adjuster's name: _____ |
| Claim Number: _____ | Agent's phone number: _____ |
| Do you have Medical Payment Coverage on your insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, your Insurance Co.: _____ |
| Policy number: _____ | Agent or adjuster's name: _____ |
| Claim Number: _____ | Agent's phone number: _____ |
| Do you have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | Company: _____ |
| ID #: _____ | Member Services' phonenumber: _____ |
| Group #: _____ | |

Make sure to give the receptionist your ID card to photocopy.