AUTOMOBILE ACCIDENT HISTORY FORM

Your Name:________________________________ Today's Date:________________

Date of Accident:____________________ Time of accident:_____ am/pm

City of Accident:____________________ Street of accident:______________

Road conditions at the time of the accident: WET DRY ICY OTHER____________

Did the police come to the accident scene? YES NO; Is there a report? YES NO

Did you go to a hospital? YES NO

If yes, what is the name and city of the hospital?__________________

How did you get to the hospital?____________________________________

What parts of your body were x-rayed at the hospital?______________

What did the hospital do for your injuries?________________________

How long did you stay at the hospital?_____________________________

What bleeding cuts did you sustain during this accident?______________

What bruises did you sustain during this accident?____________________

Where were **you** seated in the vehicle?________________________

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise? AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO; How long:________

Did you experience a flash of light or explosion in your head? YES NO

Did you become CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS from the accident? (please circle)

If you still have any of those symptoms, which ones?____________________

Are you currently suffering from any of the following (please circle):

RESTLESSNESS IRRITABLE
DIFFICULT CONCENTRATING DIFFICULT WITH MEMORY
SLEEPLESSNESS FORGETFULNESS
REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL

How far is the top of the headrest or seatback from the top of your head (approximately): __________inches above or below

Were you wearing a seatbelt? YES NO

If yes, was it a lap seatbelt ______ shoulder-lap seatbelt ______

List the year, make and model of the vehicle you were in:
year ____________ make ___________ model _____________________

Was your car stopped at the time of impact? YES NO
If yes, was the driver's foot also on the brake? YES NO
If no, then estimate the speed of the vehicle you were in: ___________mph

If your vehicle was moving at the time of impact, was it:
slowing down? YES NO
gaining speed? YES NO
traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?
head hit _______________________chest hit _______________________
right/left shoulder hit ___________right/left arm hit _______________
right/left hip hit _______________right/left leg hit ________________
right/left knee hit _______________other ___________________________

Did you receive any injury or bruise from the seat belt? YES NO
If YES, then describe: ____

What is the estimated cost damage to the vehicle you were in? $ ______________

Which of the following car parts broke during the accident? (please circle)
windshield front seat back
right/left side window other_____________________________
steering wheel other_____________________________

Was the trunk of your body pointed straight forward at the time of the collision?
YES NO; If no, how was it turned?_________________________________

Was you head pointed straight forward? YES NO; If no, what direction was it turned and by how much?____

What is the year, make and model of the **other** vehicle?
year ____________ make ___________ model _____________________

Was the other vehicle moving at the time of the collision? YES NO
If yes, what was its approximate speed? ___________mph

If the other vehicle was moving at the time of the collision, was it (please circle):
slowing down gaining speed traveling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident:____
____
____

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the *overall* impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed. **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Revised March 15, 1993

1. ***Family/Home Responsibilities.*** This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. ***Recreation.*** This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. ***Social Activity.*** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. ***Occupation.*** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. ***Self Care.*** This category includes activities which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. ***Life-Support Activity.*** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

TOTAL SCORE: ______ SIGNATURE: ______________________ DATE: ______________________

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317 Telephone: (602) 224-0220; Facsimile: (602) 224-0230

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: ____________

AGE: ________ DATE OF BIRTH: ______________ OCCUPATION: ____________________

HOW LONG HAVE YOU HAD THIS PAIN? ___YEARS ___MONTHS ___WEEKS

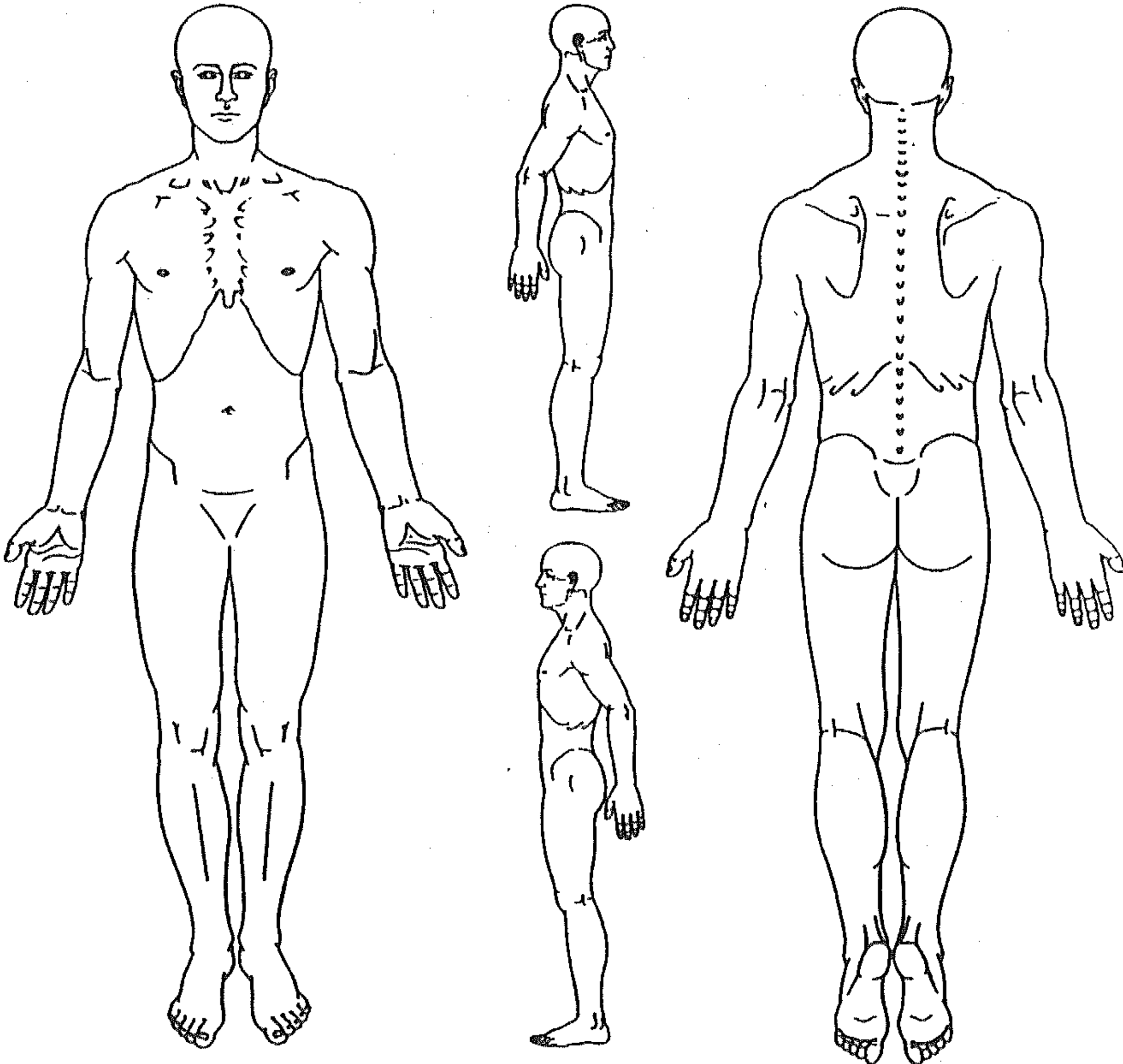
IS THIS YOUR FIRST EPISODE OF THIS PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:

A=ACHE	B=BURNING	N=NUMBNESS
P=PINS & NEEDLES	S=STABBING	O=OTHER



OVER PLEASE

For Doctor's Use:

Chief compliant (other than neck or low back pain): ______________________________

____

(For neck conditions use the Neck Pain Disability Index Questionnaire; for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire.)