AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name_____ Date_____

Date of Accident_____ City/State of Accident_____

Did the police come to the accident scene? ☐ Yes ☐ No

Were you taken to a hospital? ☐ Yes ☐ No If yes, which one? _____

What treatment was given?_____

What parts of your body were x-rayed?_____

Have you had **ANY** complaints in the involved area before? ☐ Yes ☐ No If yes, describe_____

_____

Were you seated as DRIVER? _____ FRONT SEAT PASSENGER? _____ BACK SEAT PASSENGER? _____

Were you aware of the approaching collision prior to impact? ☐ Yes ☐ No

Did you lose consciousness (black out) upon impact? ☐ Yes ☐ No

Where did you feel pain immediately after the accident? _____

_____

Were you wearing a LAP SEAT BELT? ☐ Yes ☐ No a SHOULDER SEAT BELT? ☐ Yes ☐ No

List the year, make, model of vehicle you were in _____

Was your vehicle stopped at the time of impact? ☐ Yes ☐ No If yes, was driver's foot on the brake? ☐ Yes ☐ No

If your vehicle was moving at time of accident, please estimate vehicle's speed:_____ MPH

If your vehicle was moving, was it GAINING SPEED?_____ SLOWING DOWN? _____ AT A STEADY SPEED?_____

What was the speed of the other vehicle at time of impact? _____MPH

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

_____

_____

_____

What bleeding cuts did you get during this accident? _____

What bruises did you get during this accident? _____

What part of the auto did the following body parts hit?

Head _____ Chest _____

Right/Left Shoulder _____ Right/Left Arm _____

Right/Left Hip _____ Right/Left Leg _____

Right/Left Knee _____ Other _____

Which of the following car parts broke during the accident?

Windshield _____ Front Seat Belt _____ Steering Wheel _____

Right/Left Side Window _____ Other _____

Was the trunk of your body pointed straight forward at the time of collision? ☐ Yes ☐ No

If not, what direction was it turned, and by how much? _____

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury, are your symptoms IMPROVING? _____ THE SAME? _____ WORSE? _____

Have you retained an attorney? ☐ Yes ☐ No

If yes, attorney's name _____ phone number _____

address _____

WELCOME TO OUR OFFICE !

Please Print

Patient's Name _____
First Middle Initial Last

Address _____
Street City State Zip

Home Phone #_____ Sex (circle) Male Female
Area Code

Cell Phone #_____ E-mail Address_____

Marital Status (circle) Single Married Divorced Widowed

Date of birth _____ Social Security #_____

Employment Status (circle) Student Homemaker Retired Employed

If Employed:
Employer_____ Work Phone #_____
Area Code

Work Address _____
Street City State Zip

Referred to our office by _____

In case of emergency, contact _____
Name Phone No.

Person (*if someone other than patient*)
responsible for payment of this account _____
Name Relationship to Patient

All fees are the responsibility of the patient or the responsible party listed above. As a courtesy to me, this office will file the insurance claim for me. However, should the balance not be paid by the insurance company, I understand it will be my responsibility to pay the account balance. I also understand that if my account is forwarded to collections, I will be responsible for any and all additional charges added to my past-due account plus any charges for litigation, attorney fees, court costs and filing fees. I hereby authorize payment to Dr. Robert Beck of benefits due me for his services as described. I also authorize the release of any and all medical information relating to this claim.

_____ _____
Signature of Patient or Responsible Party Date

PAIN DIAGRAM

*NAME:*_____ *AGE:*_____

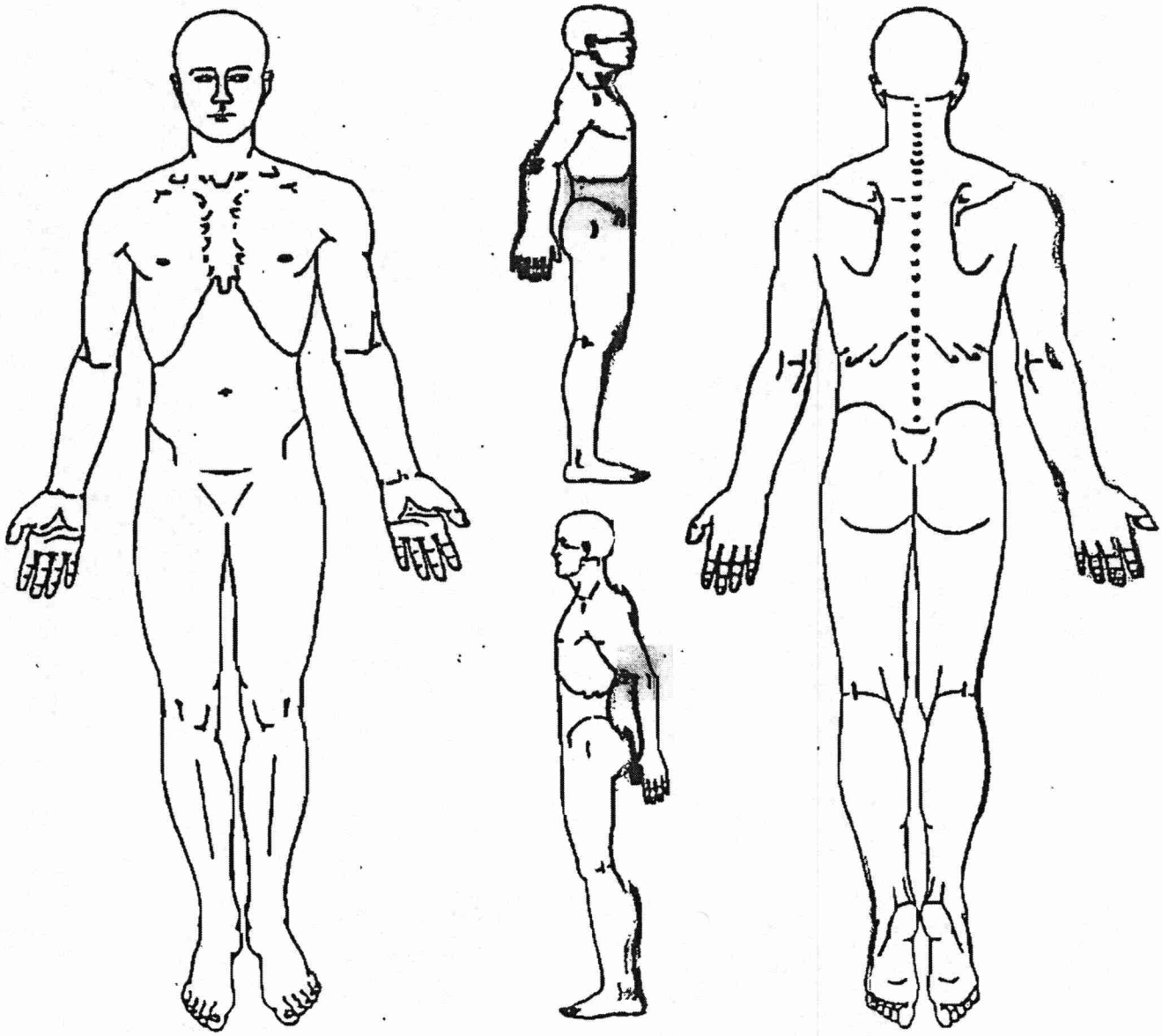
*DATE:*_____

How long have you had this problem?_____

Is this your first episode of this pain/discomfort?_____

On these diagrams, please mark where you are experiencing pain/discomfort right now.
Use the letters below to indicate the type of discomfort.

A= Ache
B= Burning
N= Numbness
P= Pins & Needles
S= Stabbing
0= Other (explain)

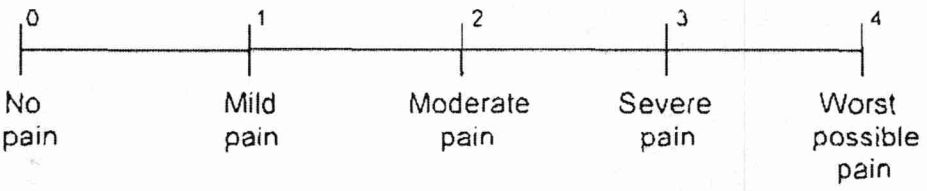


Functional Rating Index

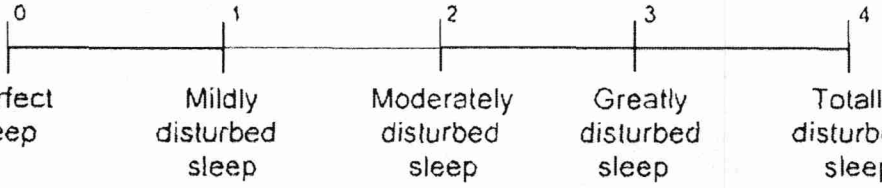
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

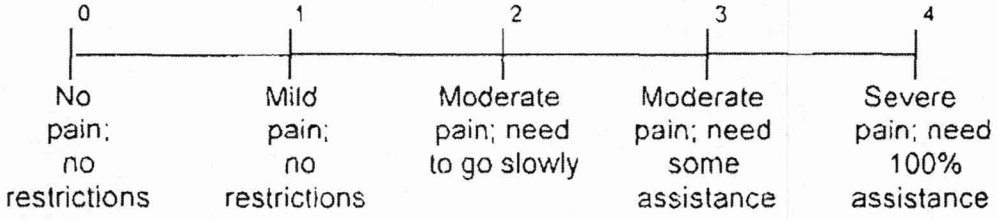
1. Pain Intensity



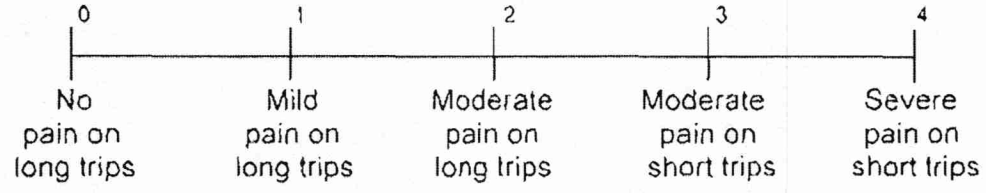
2. Sleeping



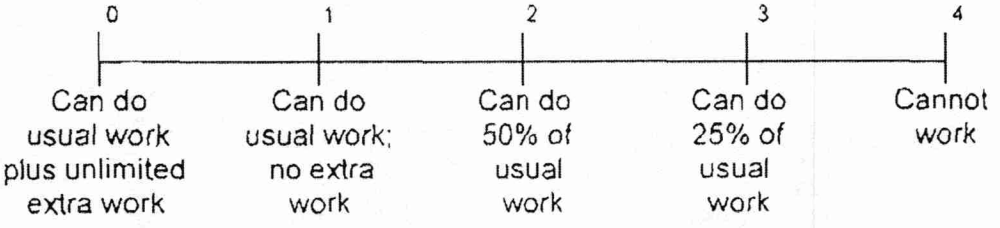
3. Personal Care (washing, dressing, etc.)



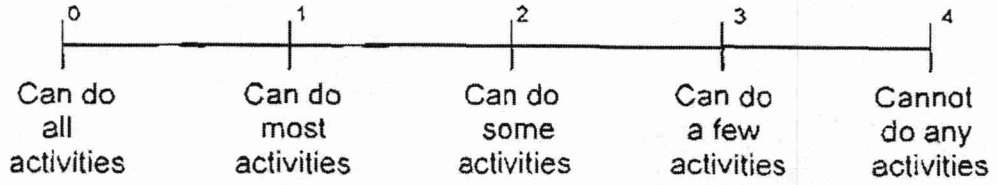
4. Travel (driving, etc.)



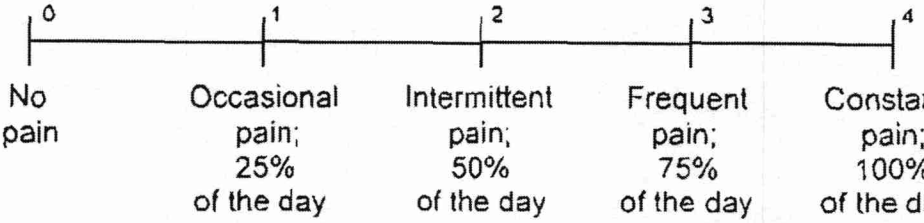
5. Work



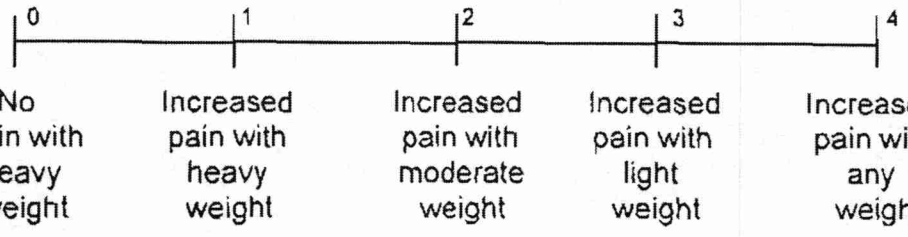
6. Recreation



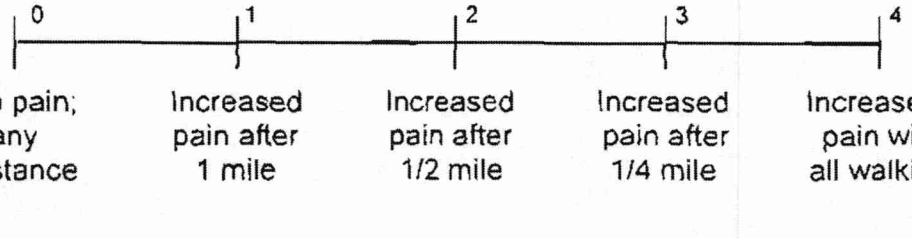
7. Frequency of pain



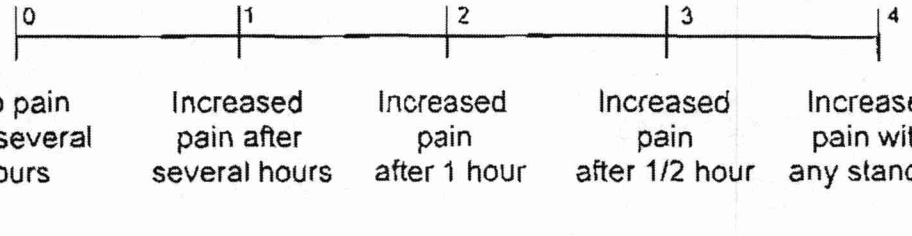
8. Lifting



9. Walking



10. Standing



Patient's Signature

Score =

Date