MultiCare Medical

Auto Accident History and Questionnaire

701 Pinnacle Drive
Suite #105
(72nd & Cornhusker)

Today's Date_____ Patient Number (Office Use)_____

Patient Name (Last, First, Middle)_____

Birth date:_____Age:_____ Gender: Male ☐ Female ☐

Date & Time of Accident:_____Where was the accident? (city/state)_____

Describe the accident:_____

Were there other people in your car during the accident? ☐Y/☐N If yes, who?_____

Was a police report filed? ☐Y/☐N How many vehicles were involved?_____

Your vehicle make & model:_____Other vehicle make & model:_____

What direction and street were you travelling?_____

What direction and street was the other car travelling?_____

Were you caught by surprise? ☐Y/☐N Did you have a seat belt on? ☐Y/☐N Was shoulder harness on? ☐Y/☐N

Did you brace your arms/hands against the vehicle? ☐Y/☐N If yes, which part?_____

Did you brace your legs against the floorboard? ☐Y/☐N Was your foot on the brake? ☐Y/☐N

Where were you looking at the time of impact?_____ Position of torso at time of impact?_____

Did any other part of your body hit the interior of the vehicle? ☐Y/☐N If yes, what/where?_____

Did you have a headrest? ☐Y/☐N What position was it in? ☐high ☐mid ☐low ☐non-moveable

What part of your car was impacted?_____

During and after the carsh, what happened to your vehicle? (kept going, spun around etc)_____

Your car was: ☐in park ☐in gear ☐stopped ☐in neutral ☐moving MPH?_____

Other vehicle #1: ☐in park ☐in gear ☐stopped ☐in neutral ☐moving MPH?_____

Other vehicle #2: ☐in park ☐in gear ☐stopped ☐in neutral ☐moving MPH?_____

What are the estimated damages to your car?_____ Damage details?_____

Where did you immediately notice pain or symptoms?_____

Where were you located in the car? _____

Were you unconscious? ☐Y/☐N If yes, for how long?_____

Did you go to the hospital/ER? ☐Y/☐N If so, where did you?_____ And when?_____

Did you go to the hospital by ambulance? ☐Y/☐N Did you require a neck/back brace? ☐Y/☐N

Please list any medications/supplies given to you by the ambulance workers:_____

Hospitalization

Were you hospitalized? ☐Y/☐N Were you there overnight? ☐Y/☐N

What medications did you receive? _____

Were xrays taken? ☐Y/☐N If yes, what areas? _____

What diagnosis was given?_____

What were the doctor's recommendations? _____

Follow up care

Since the accident are your symptoms: ☐Better ☐Worse ☐Same

Have you seen any doctors since? ☐Y/☐N If yes, what doctor and where? _____

What was their diagnosis?_____

Did they recommend any treatment? ☐Y/☐N If yes, please explain: _____

What medications or treatments have you received? _____

Have you had similar symptoms in the past? ☐Y/☐N If yes, please explain:_____

Have you lost any days from work? ☐Y/☐N If yes, how many and dates:_____

What is your occupation?_____What are your job requirements?_____

Is there anything else you'd like us to know? Please use the space below.

_____

_____

_____

Signature:_____ Date:_____