

Vancouver Spine & Orthopedic Rehabilitation Center, PLLC
Motor Vehicle Accident Patient History

Patient Name: _____ Date: _____

What state did the accident happen in? _____

1. Date of Accident: _____ 2. Time: _____ AM/PM

2. Were you the driver of the car? Yes No

3. Were you the passenger of the car? Yes No

4. Where were you seated? _____

5. Who owns the car? _____

6. Year/Model of Car: _____

7. What was the approximate damage to your car? _____

8. Visibility at time of accident: Poor/Fair/Good/Other: _____

9. Road conditions at time of accident: Icy/Rainy/Wet/Clear/Dark/Other: _____

Describe: _____

10. Where was your car struck? Right/Left/Rear/Front/Side/Other: _____

Describe: _____

11. Type of accident: head-on collision broad side collision rear-end collision
 front impact, rear-end car in front 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 you wearing seatbelts? Yes NO

16. Does your car have headrests Yes NO

17. If yes, what was the position of the headrest compared to your head before the accident? top of headrest even with bottom of head top of headrest even with the top of head top of headrest even with middle of neck

18. Was your car braking? Yes No Was your car stopped Yes No

19. Was your car moving at the time of the accident? Yes No

20. If yes, how fast would you estimate you were going? _____ Mph

21. 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:

22. At the time of accident, what parts of your head or body hit the inside of your car?

23. As a result of the accident were you: rendered unconscious dazed

other: _____

24. Could you move all parts of your body following the trauma? Yes No

25. If no, what parts and why? _____

26. Did you require any assistance to get out of the car? Yes No

27. If no, why not? _____

28. Did you get cuts or bruises? Yes No

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29. If yes, what cuts or bruising did you get from the incident?

30. Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

31. Please check your symptoms since the accident:

- | | | |
|--|--|--|
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of smell | <input type="checkbox"/> numbness in fingers |
| <input type="checkbox"/> neck pain/stiffness | <input type="checkbox"/> loss of taste | <input type="checkbox"/> cold fingers |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> loss of memory | <input type="checkbox"/> cold feet |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> light sensitive eyes | <input type="checkbox"/> tension | <input type="checkbox"/> constipation |
| <input type="checkbox"/> pain behind eyes | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> irritability | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> fainting | <input type="checkbox"/> depression | <input type="checkbox"/> cold sweats |
| <input type="checkbox"/> ringing/buzzing in ears | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> anxious |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> numbness in toes | <input type="checkbox"/> other |

32. Occupation: _____

33. Have you missed time from work? Yes No

34. If yes, how much time? _____

35. Did you seek medical help immediately after the accident? Yes No

Where? _____

36. If yes, how did you get there? someone drove you ambulance

drove your own car police other: _____

37. Were you hospitalized as a result of this accident? Yes No

38. If yes, where were you hospitalized? _____

Please diagram how the accident happened