

Patient name: _____

Auto Accident History

Today's Date: ___/___/___

Date of Birth: ___/___/___

Accident Date: ___/___/___

Circle the answer for each question to insure the best treatment and most accurate reports to the insurance.

Symptom History

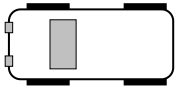
Body Part (incl. Lt or Rt)	Symptom (dizzy, pain, ache, tingling, etc.)	When did symptom begin? (circle one) (approximately how many)	My symptom is <u>now...</u>	Office Use FREQ	Severity now 0 = None 10 = worst imaginable	Office Use Prior Severity
		Immediate / ___hrs / ___days	Worse / Same / Better / Gone	C I F O	0 1 2 3 4 5 6 7 8 9 10	
		Immediate / ___hrs / ___days	Worse / Same / Better / Gone	C I F O	0 1 2 3 4 5 6 7 8 9 10	
		Immediate / ___hrs / ___days	Worse / Same / Better / Gone	C I F O	0 1 2 3 4 5 6 7 8 9 10	
		Immediate / ___hrs / ___days	Worse / Same / Better / Gone	C I F O	0 1 2 3 4 5 6 7 8 9 10	
		Immediate / ___hrs / ___days	Worse / Same / Better / Gone	C I F O	0 1 2 3 4 5 6 7 8 9 10	
		Immediate / ___hrs / ___days	Worse / Same / Better / Gone	C I F O	0 1 2 3 4 5 6 7 8 9 10	

Were you rendered unconscious?	Yes	No	If yes, ___ minutes or ___ hours
Circle any you have experienced: <small>[if early, possible CT]</small>	Amnesia, Forgot things		Unusual confusion
			Less Alert
How did you leave the accident?	Drove		Passenger
			Ambulance
Have you been treated for these symptoms?	Yes	No	by Who? _____
--circle all that you received	x-rays	medications	other _____

Body Position upon Impact

Where were you seated?	Driver	Front Passenger	Back Left	Back Right
Were you wearing a Seatbelt?	Yes	No		
Was your headrest high enough?	Yes	No		
Head Position...Looking...	Left	Forward	Right	Unknown
			Other	
Were you aware of impending impact?	Yes	No		

IMPACT History (All questions refer to **YOUR** car, unless stated otherwise.)

Approximate speed:	_____ mph	?	
Other vehicle approx. speed	_____ mph	?	
Mark the Site (on your car) that contacted the other object(s):	<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px dashed gray; padding: 2px; margin-right: 5px;">Front</div>  <div style="border: 1px dashed gray; padding: 2px; margin-left: 5px;">Back</div> </div>		
Was the car able to be driven immediately after accident	Yes	No	
Your car size:	Compact	Midsize	Full size
	Sm. Truck	Lg. Truck/Van	Other
Their car size:	Compact	Midsize	Full size
	Sm. Truck	Lg. Truck/Van	Other
Did your body hit anything in the vehicle	Yes	No	
If yes, Body Part(s) _____	Vehicle Part(s) _____		
Was a police report filed?	Yes	No	

Miscellaneous

Has your insurance been contacted?	Yes	No	
Have you contacted an attorney?	Yes	No	If so, who? _____

Abbrev Key – C – Constant, I – Intermittent (Several times each day or often during a certain activity), F – Frequent (Multiples times or hours per day or each time during a common activity), O – Occasional (Sometimes or minutes per day or each time during a uncommon activity)

9. Shackford SR, Wald SL, Ross SE, et al. The clinical utility of computed tomographic scanning and neurologic examination in the management of patients with minor head injuries. J Trauma 1992;33:385-394.

10. Stein SC, Ross SE. Mild head injury: A plea for routine early CT scanning. J Trauma 1992;33:11-13.

11. Livingston DH, Loder PA, Koziol J, Hunt CD. The use of CT scanning to triage patients requiring admission following minimal head injury. J Trauma 1991;31:483-489.

28. Stein SC, Ross SE. The value of computed tomographic scans in patients with low-risk head injuries. Neurosurgery 1990;26:638-640.

31. Dacey RG Jr, Alves WM, Rimel RW, Winn HR, Jane JA. Neurosurgical complications after apparently minor head injury. Assessment of risk in a series of 610 patients. J Neurosurg 1986;65:203-210.