The Hetrick Center
Personal Injury Questionnaire

Patient Name: _____ **Patient DOB:** _____
Date of Accident: _____ Time of Accident: _____
Location of Accident: _____

Make / Model / Year of your car: _____
Make / Model / Year of other car(s): _____

In your own words, how did the accident occur? _____
_____

You were the: Driver Front Seat Passenger
(circle one) Backseat Passenger (Driver's side) Backseat Passenger (Passenger's side)
How many people were in your vehicle? _____ **The other vehicle(s)?** _____
What type of damage was done to your vehicle: _____
_____
What type of damage was done to the other vehicle(s) involved? _____
_____
Do you have any photographs of your vehicle following the accident? Yes ___ No ___

Were you aware the accident was going to happen (ie. did you see it coming)? Yes ____ No ____
Did you hear tires screeching? Yes ____ No ____
If you struck the vehicle in front of you, did you hit: (circle one)
In the center Off to the left Off to the right
If you were hit from behind, was the impact: (circle one)
In the center Off to the left Off to the right

Was your foot on the brake at the time of impact? Yes ___ No ___
If yes, did your car move forward after impact? Yes ___ No ___
Where did your vehicle end up after the accident? (ex: didn't move, moved slightly, ended up in a ditch, etc.)
_____
_____
Where did the other vehicle(s) involved end up after the accident? _____
_____
Did anything in your vehicle strike you? Yes ___ No ___
If yes, what hit you and where did it hit you? _____
What was the position of your head at the time of impact? (ex: turned left or right, looking straight ahead, looking in rearview mirror, etc.) _____
Did your head strike anything in your vehicle? Yes ___ No ___
If yes, what? _____
What were the positions of your hands at the time of impact? (ex: on the steering wheel, resting on the arm rest, etc.) _____
What were the positions of your legs/feet at the time of impact? (ex: on brake, etc.)
_____

Were you sitting straight up in your seat at the time of impact? Yes ___ No ___
If no, how were you sitting? _____
What was the distance from the back of your head to the headrest? _____ inches
What was the height of your headrest? _____
Were you wearing the appropriate seat restraints? Yes ___ No ___
If yes, circle which one(s): Shoulder Restraints Lap Restraints Both

If you were wearing eyeglasses/sunglasses, did they remain on your face? Yes___ No___
If yes, did you have to readjust them after the impact? Yes ___ No ___
Were you wearing any accessories on your head? Yes ___ No ___
If yes, what accessories were you wearing? _____
Did they remain on your head at impact? Yes ___ No ___
Do you remember your head being whipped back and forth? Yes ___ No ___
If yes, in which direction? _____
Did your airbags deploy? Yes ___ No ___ **(If yes, circle)** front side curtain both

Did you have to be extricated from your vehicle? Yes ___ No ___
Were you able to get out of your vehicle on your own? Yes ___ No ___
Were you examined and/or treated by an emergency medical crew at the site of the accident? Yes ___ No ___
Were you taken from the accident via ambulance? Yes ___ No ___
If you went to the hospital, whether in an ambulance or on your own, where were you taken?
_____

Have you been examined/treated by any other health care providers for your accident?
Yes ___ No ___ If yes, who? _____
When? _____
Where? _____
How often? _____
Have you been prescribed any medications for conditions sustained in this accident? Yes ___ No ___
If yes, what have you been prescribed? _____
_____
Have you had any special studies (ie x-rays, MRI, CT scan, etc.) performed as a result of this accident?
Yes ___ No ___ If yes, what? _____

Did you have any visible injuries immediately after the accident? Yes ___ No ___
If yes, what? _____
Do you have photos of the injuries? Yes ___ No ___

If this is more than 3 days after the accident, have you noticed any bruising on your body? Yes ___ No ___
If yes, where? _____

Do you remember everything from the time of the impact until after the impact? Yes ___ No ___
Did you lose consciousness as a result of the accident? Yes ___ No ___
Have you noticed any visual disturbance as a result of the accident? Yes ___ No ___
Were you nauseated as a result of the accident? Yes ___ No ___
Did you vomit within the first 24 hours following the accident? Yes ___ No ___
Were you or are you feeling dizzy? Yes ___ No ___
Are you experiencing jaw pain? Yes ___ No ___ If yes, circle: Left Right Both

What symptoms do you have as a result of the accident? _____
_____
_____
If you have pain, describe it (ie sharp, dull, burning, radiating, etc.): _____
_____
What is your pain level on a 0-10 scale (0 = no pain to 10 = worst pain you could ever imagine)?
Pain level currently _____/10
Pain level when you're feeling your best _____/10
Pain level when you're feeling your worst _____/10
Does your pain radiate into your arm(s) and/or leg(s)? Yes ___ No ___
If yes, describe it _____

Are your symptoms *(circle one)*: Getting worse? Staying the same? Getting better?

Did you hear anything pop, snap, or tear during or after the accident? Yes ___ No___

Does anything make your pain better? _____
_____
Does anything make your pain worse? _____
_____
Is your pain worse with coughing, sneezing, and/or going to the bathroom? Yes __ No__
Have there been any changes in bowel/bladder function since the accident? Yes __ No__

Are your current symptoms with you 20%, 50%, 75%, or 100% of the time?
Symptoms I feel 25% of the time are_____
Symptoms I feel 50% of the time are_____
Symptoms I feel 75% of the time are_____
Symptoms I feel 100% of the time are_____

Have you ever been involved in a motor vehicle accident in the past? Yes ___ No ___
If yes, when? _____
Accident details: _____
_____
Did you have any complaints prior to the accident you were involved in? Yes ___ No ___
If yes, please list these areas and write the pain level (0 to 10) prior to the accident:
Complaints prior to this accident: _____
_____
Pain levels prior to this accident:
Pain level at best ____/10 Pain level on average ____/10 Pain level at worst ____/10
Have you returned to work since the accident? Yes ___ No ___
If yes, *(circle)*: FT PT Intermittent
If yes, are you on limited duty? Yes ___ No ___
Are you having difficulty performing your daily activities? Yes ___ No ___
If yes, what do you have difficulty performing? _____
_____
Have you had difficulty sleeping since the accident? Yes ___ No ___
If yes, describe: _____

Is there anything else we have not asked you that you feel is pertinent to this case?

_____

_____

_____

I have answered the above truthfully and to the best of my knowledge.

Patient's Printed Name: _____

Patient's Social Security Number: _____

Patient Signature _____ **Date** _____

THC Provider Signature _____ **Date** _____

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