



***MOTOR VEHICLE ACCIDENT QUESTIONNAIRE***

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

- Date of Accident? \_\_\_\_\_ Time of Accident? \_\_\_\_\_
- Location of Accident: \_\_\_\_\_
- In your own words, how did the accident occur? \_\_\_\_\_  
\_\_\_\_\_
- Were you the driver or a passenger in the automobile? \_\_\_\_\_. If you were a passenger, what position were you sitting in the automobile? \_\_\_\_\_
- How many people were in your vehicle? \_\_\_\_\_ Other vehicle(s)? \_\_\_\_\_
- What is the make, model and year of your automobile? \_\_\_\_\_
- What is the make, model and year of the other vehicle(s) \_\_\_\_\_
- What were the road surface conditions (dry, wet, snow, ice, etc.)? \_\_\_\_\_
- How fast were you traveling? \_\_\_\_\_; The other vehicle? \_\_\_\_\_
- What type of damage was done to your vehicle? \_\_\_\_\_
- What type of damage was done to the other involved vehicle(s)? \_\_\_\_\_
- Were you aware the accident was going to occur, did you see it coming? \_\_\_ Yes \_\_\_ No
- Did you hear any tires screeching? \_\_\_ Yes \_\_\_ No
- If you struck the vehicle in front of you, did you hit it straight on, off to the left or off to the right? \_\_\_\_\_
- If you were hit from behind, was the impact more from the center, or more to the left or 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? (I.e. did not move, moved slightly, ended in a ditch, etc.) \_\_\_\_\_
- Where did the other involved automobile(s) end up after the accident?  
\_\_\_\_\_
- Did anything in the vehicle strike you? \_\_\_ Yes \_\_\_ No. If yes, what and where?  
\_\_\_\_\_

- What was the position of your head (looking/turned to the left/right, looking straight ahead, looking in the rearview mirror etc.)? \_\_\_\_\_
- What was the position of your hands on the steering wheel at the time of the accident? (i.e. 10 & 2 o'clock) \_\_\_\_\_
- What was the position of your legs/feet? \_\_\_\_\_
- Were you sitting straight up? \_\_\_ Yes \_\_\_ No. If you weren't, were you leaning to the side (Right or Left), slumped in your chair, etc.? \_\_\_\_\_
- 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. Were you wearing: shoulder restraints, lap restraints or both? \_\_\_\_\_
- If you were wearing eyeglasses/sunglasses, did they remain on your face? \_\_\_ Yes \_\_\_ No. Did you have to readjust your glasses after impact? \_\_\_ Yes \_\_\_ No.
- Were you wearing any accessories on your head? \_\_\_ Yes \_\_\_ No. Were the accessories still on your head after the accident? \_\_\_ Yes \_\_\_ No. What accessories are you referring to? \_\_\_\_\_
- Do you have any pictures of your vehicle following the accident? \_\_\_ Yes \_\_\_ No
- Do you remember your head being whipped back and forth? \_\_\_ Yes \_\_\_ No If yes, which direction was your head whipped? \_\_\_\_\_
- Did your head strike anything in the vehicle? \_\_\_ Yes \_\_\_ No. If yes, what? \_\_\_\_\_
- Were your airbags released? \_\_\_ Yes \_\_\_ No
- Did you have to be extricated out of the vehicle? \_\_\_ Yes \_\_\_ No. Were you able to get out of the car on your own? \_\_\_ Yes \_\_\_ No
- Were you taken from the accident via ambulance? \_\_\_ Yes \_\_\_ No. Were you examined and/or treated by an emergency medical crew at the site of the accident? \_\_\_ Yes \_\_\_ No If you went to the hospital, whether via ambulance or on your own, where were you taken? \_\_\_\_\_
- Have you been examined/treated by any other health care providers? \_\_\_ Yes \_\_\_ No. If yes, please tell us who?/when?/where?/how often?/etc. \_\_\_\_\_  
\_\_\_\_\_
- Have you been prescribed any medications for conditions sustained in this motor vehicle accident? Yes or No. If yes, what have you been prescribed? \_\_\_\_\_  
\_\_\_\_\_

- Have you had any special studies (x-rays, CAT scans, MRI's, etc.) performed for this accident? Yes or No. If yes, what? \_\_\_\_\_  
\_\_\_\_\_
- Did you have any visible injuries immediately after the accident? Yes or No. If yes, what? \_\_\_\_\_ Do you have any pictures of the visible injuries? \_\_Yes \_\_ No. If this is more than 3 days after the accident, have you noticed any bruising on your body? \_\_Yes or \_\_No. If yes, where? \_\_\_\_\_
- Have you ever been involved in a motor vehicle accident in the past? If yes, what date? \_\_\_\_\_ Nature of the accident \_\_\_\_\_
- 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 disturbances as a result of the accident? \_\_Yes \_\_ No. Have you had any ringing of the ears? \_\_Yes \_\_ No. Anything else? \_\_\_\_\_
- 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 dizzy? \_\_Yes \_\_ No.
- Are you experiencing any jaw pain? \_\_Yes \_\_ No. Right / Left / Bilateral.
- What symptoms do you have as a result of the accident (i.e. neck/back pain, arm/leg pain, headaches, extremity complaints, etc.)? \_\_\_\_\_  
\_\_\_\_\_

Describe your pain i.e. burning, sharp dull, etc. \_\_\_\_\_  
\_\_\_\_\_

Do you have any radiating arm or leg pain? \_\_Yes \_\_No.

- Are you symptoms? \_\_Getting Worse \_\_Staying the same \_\_Getting Better
- Does anything make your pain better or worse?  
Describe: \_\_\_\_\_
- Is your pain worse with coughing, sneezing or going to the bathroom? \_\_Yes \_\_No.
- Have there been any changes in bowel/bladder function since the accident? \_\_Yes \_\_ No.
- Are you having any problems with memory or concentration as a result of your motor vehicle accident? \_\_Yes \_\_ No. Describe: \_\_\_\_\_
- Did you hear anything pop, snap or tear during or after the accident? \_\_Yes \_\_ No.
- What is your current pain level (0-10 scale), with 0 being no pain and 10 being the worst pain that you could ever imagine? \_\_\_\_\_/10 When you feel the best, what is your pain level? \_\_\_\_\_/10 When you feel the worst, what is your pain level? \_\_\_\_\_/10.

- Are your current symptoms with you 25%, 50%, 75% or 100% of the time...Mark down which symptoms are with you via those percentages?

100% \_\_\_\_\_

75% \_\_\_\_\_

50% \_\_\_\_\_

25% \_\_\_\_\_

- Did you have any complaints prior to the accident you were involved in?  Yes  No.  
If yes, list these areas and write what the pain level (1 to 10 ) was prior to the motor vehicle accident at its best, worst, average

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Have you worked since the accident?  Yes  No; If yes,  FT  PT  Intermittent
- If yes to above, are you on limited duty?  Yes  No. Describe: \_\_\_\_\_
- Are you having difficulty performing your daily activities?  Yes  No. If yes, what are you having difficulty performing? \_\_\_\_\_

\_\_\_\_\_

- Are you having difficulty sleeping since the accident?  Yes  No. Describe:

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Revised: 03.05.03



**The Hetrick Center**  
"Your Multidisciplinary Solution"

# PATIENT HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 S.S.N.: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Tel #: \_\_\_\_\_  
 Emergency Contact Person: \_\_\_\_\_ Tel#: \_\_\_\_\_  
 Do you have Advance Directives or a delineated power of attorney for your medical care? Y N (If yes, please provide us with a copy)

List, in order of importance, your Primary Medical Issues that bring you to The Hetrick Center:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

List, in order of importance, other Medical Issues you may be seeing other providers for: (List issue & provider)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Have you ever had x-rays? Y N If Yes: Date: \_\_\_\_\_ For what: \_\_\_\_\_  
 Have you ever had MRI's? Y N If Yes: Date: \_\_\_\_\_ For what: \_\_\_\_\_  
 Have you ever had other tests/studies? Y N If yes list below:

1. Date: \_\_\_\_\_ Study/Test: \_\_\_\_\_ Treatment received: \_\_\_\_\_
2. Date: \_\_\_\_\_ Study/Test: \_\_\_\_\_ Treatment received: \_\_\_\_\_
3. Date: \_\_\_\_\_ Study/Test: \_\_\_\_\_ Treatment received: \_\_\_\_\_

Have you seen any other providers for your presenting complaint(s) today? Y N If yes, list their name and specialty: \_\_\_\_\_  
 What types of treatment(s) have you received, if any, for your presenting condition(s)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What medications and dosages are you currently taking?  
 \_\_\_\_\_  
 \_\_\_\_\_

Please mark with an "x" the following that you have taken in the past 2 months: \_\_\_vitamins \_\_\_herbs  
 \_\_\_laxatives  
 \_\_\_stomach/GI/reflux medicine \_\_\_birth control pills \_\_\_beta blockers \_\_\_muscle relaxers \_\_\_pain medicine  
 \_\_\_cold/cough medicine \_\_\_hormone replacements \_\_\_appetite curb pills \_\_\_thyroid medication \_\_\_insulin



Is your current condition related to a work injury or an automobile accident? Y N If yes, which one? \_\_\_\_\_

Have you ever been in an automobile accident? \_\_\_past year \_\_\_past 5 years \_\_\_over 5 years ago \_\_\_never

Have you ever sustained a work injury for which you received treatment? Y N If yes, when? \_\_\_\_\_

Please check the following conditions that you have or have had:

\_\_\_AIDS \_\_\_Anemia \_\_\_Arthritis \_\_\_Cancer \_\_\_Diabetes \_\_\_Epilepsy \_\_\_Hardening of the arteries  
\_\_\_Heart attack \_\_\_High blood pressure \_\_\_Low blood sugar \_\_\_Multiple sclerosis \_\_\_Parkinson's Disease  
\_\_\_Polio \_\_\_Rheumatic fever \_\_\_Stroke \_\_\_Tuberculosis \_\_\_Venereal Disease

Please mark if you have any of the following symptoms:

**Head**

\_\_\_Unusually frequent headaches \_\_\_Unusually severe headaches \_\_\_Head feels heavy \_\_\_Vertigo \_\_\_ facial numbness

\_\_\_Light-headedness \_\_\_Loss of smell \_\_\_Loss of taste \_\_\_Loss of balance \_\_\_Previous head trauma

**Neck**

\_\_\_Neck pain with movement \_\_\_Swelling in neck \_\_\_Stiff neck \_\_\_Pinched nerve in neck \_\_\_dizziness with neck movement

\_\_\_Neck feels out of place \_\_\_Muscle spasms in neck \_\_\_Abnormal sounds in neck \_\_\_Previous neck injury

**Shoulders**

\_\_\_Pain in shoulder (right or left) \_\_\_Pain across shoulders \_\_\_Tension in shoulders

\_\_\_Muscle spasms in shoulders \_\_\_Can't raise arm above shoulder level \_\_\_Can't raise arm over head

**Arms & Hands**

\_\_\_Pain in upper arm \_\_\_Pain in forearm \_\_\_Pain in hands \_\_\_Pain in fingers \_\_\_Fingers go to sleep

\_\_\_Sensation of pins and needles (\_\_\_in arms \_\_\_in fingers) \_\_\_Cold hands \_\_\_Swollen finger joints

\_\_\_Sore finger joints \_\_\_Loss of grip strength

**Mid back**

\_\_\_Pain between shoulder blades \_\_\_Mid back pain \_\_\_Pain from front to back \_\_\_Pain over kidney area

\_\_\_Muscle spasms in mid back \_\_\_ pain below shoulder blades with exercise

**Low back**

\_\_\_Low back pain \_\_\_Low back feels out of place \_\_\_Muscle spasms in low back

**Hips, Legs, & Feet**

\_\_\_Pain in buttocks \_\_\_Pain down leg \_\_\_Knee pain \_\_\_Leg cramps \_\_\_Sensation of pins and needles

\_\_\_Numbness in legs \_\_\_Numbness in toes \_\_\_Cold feet \_\_\_Swollen ankles \_\_\_Swollen feet

**Cardiovascular**

\_\_\_General swelling \_\_\_Swelling in legs \_\_\_Swelling in face \_\_\_Swelling around eyes \_\_\_Chest pain

\_\_\_Pounding heartbeat \_\_\_Heart "jumps" \_\_\_Rapid heartbeat \_\_\_Irregular heartbeat \_\_\_Blue or purple skin

\_\_\_Fainting \_\_\_High blood pressure \_\_\_Poor circulation \_\_\_Heart murmurs \_\_\_Difficulty laying flat

\_\_\_Chest pain with exercise

**Hair, Skin, & Nails**

\_\_\_Baldness \_\_\_Dry scalp \_\_\_Oily scalp \_\_\_Eczema \_\_\_Psoriasis \_\_\_Itchy skin \_\_\_Rough, scaly scalp

\_\_\_Dry skin \_\_\_Oily skin \_\_\_Yellow skin \_\_\_Bruise easily \_\_\_Pale skin \_\_\_Rashes \_\_\_Skin cancer

\_\_\_Sensitive skin \_\_\_Paper thin nails \_\_\_Nail biting \_\_\_Allergies to Chlorine/Bromine

**Eyes**

\_\_\_Blurred vision \_\_\_Double vision \_\_\_Eyes fatigue easily \_\_\_Excessive tearing \_\_\_Lack of tearing

\_\_\_Light bothers eyes \_\_\_Excessive itching \_\_\_Pain in eyeball (s) \_\_\_Periods of blindness in eye (s)

\_\_\_Red eyes \_\_\_Night blindness \_\_\_Pain behind eyes

**Ears**

\_\_\_Loss of hearing \_\_\_Pain in ears \_\_\_Discharge from ears \_\_\_Vertigo \_\_\_Ringing in ears

**Nose/Nasopharynx/Sinuses**

\_\_\_Unusual nasal discharge \_\_\_Nose bleeds \_\_\_Pressure over eyes \_\_\_Pressure under eyes \_\_\_Frequent colds

\_\_\_Obstruction of nose \_\_\_Sinusitis \_\_\_Nasal allergies \_\_\_Loss sense of smell \_\_\_Any trauma to nose

**Mouth & Throat**

\_\_\_Pain in mouth \_\_\_Pain in throat \_\_\_Bleeding gums \_\_\_Cavities \_\_\_Abscessed teeth \_\_\_Dentures

\_\_\_Difficulty swallowing \_\_\_Changes in voice



**Respiratory**

\_\_\_ Shortness of breath \_\_\_ Asthma \_\_\_ Chronic cough \_\_\_ Difficulty breathing while lying down \_\_\_ Dry cough  
\_\_\_ Difficulty sleeping while lying down \_\_\_ Productive cough \_\_\_ Coughing up blood \_\_\_ Wheezing  
\_\_\_ Abnormal chest x-ray

**Gastrointestinal**

\_\_\_ Poor appetite \_\_\_ Constant nibbling \_\_\_ Indigestion \_\_\_ Stomach upsets from food \_\_\_ Stomach upsets from liquid \_\_\_ Stomach upsets from medicines \_\_\_ Abdominal pains \_\_\_ Stomach gas before meals \_\_\_ Stomach gas with meals \_\_\_ Stomach gas after meals \_\_\_ Change in bowel habits \_\_\_ Diarrhea \_\_\_ Constipation  
\_\_\_ Hemorrhoids \_\_\_ Ulcers \_\_\_ Loss of bowel control \_\_\_ Jaundice \_\_\_ Liver disease \_\_\_ Hepatitis \_\_\_ Gall bladder disease \_\_\_ Abdominal bloating

**Genitourinary**

Urination is: Frequent / Infrequent? Amount is: High / Low? \_\_\_ Need to get up at night to urinate \_\_\_ Difficult to start/stop urination \_\_\_ Painful urination \_\_\_ Dribbling \_\_\_ Incontinence \_\_\_ Blood in urine \_\_\_ Cloudy urine  
\_\_\_ Lack of bladder control \_\_\_ Back pain with urination \_\_\_ Stream flow abnormality

**Female Only**

\_\_\_ Painful periods \_\_\_ Missed menstrual periods \_\_\_ Irregular cycles \_\_\_ Spotting \_\_\_ Vaginal discharge  
\_\_\_ Premenstrual symptoms \_\_\_ Lumps in breasts \_\_\_ Wear an IUD \_\_\_ # of pregnancies \_\_\_ # of deliveries \_\_\_ # of vaginal deliveries \_\_\_ # of C-sections \_\_\_ Complicated deliveries \_\_\_ LBP w/ menses \_\_\_ LBP w/ pregnancy  
\_\_\_ Fibroid tumors \_\_\_ Ovarian cysts \_\_\_ Nipple discharges \_\_\_ Tubal pregnancy \_\_\_ Date of last menstrual period \_\_\_ Excessive menstrual flow \_\_\_ PMS symptoms

**Male Only**

\_\_\_ Impotence \_\_\_ Testicular swelling/pain \_\_\_ Testicular masses \_\_\_ Blood in sperm \_\_\_ Prostate disease  
\_\_\_ Premature ejaculation

**Cancer**

Do you have a history of cancer? Y N If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**General Health Questions**

Do you use tobacco products? Y N If yes, indicate what kind, how much you use, and for how long you have used the products \_\_\_\_\_

If you do not curectly use tobacco, have you ever used the products? Y N If yes, describe what you used, how long did you use the product, and when you quit \_\_\_\_\_

Do you drink alcohol? Y N If yes, how much do you consume per week \_\_\_\_\_

Is your history significant for recreational drug use? Y N Describe \_\_\_\_\_  
\_\_\_\_\_

My diet is \_\_\_ balanced \_\_\_ not balanced.

My rest is \_\_\_ sufficient \_\_\_ insufficient.

My recreation is \_\_\_ sufficient \_\_\_ insufficient.

My family stress is \_\_\_ severe \_\_\_ moderate \_\_\_ minimal \_\_\_ none.

How do you like your work? \_\_\_ above average \_\_\_ average \_\_\_ below average \_\_\_ N/A

My job stress is \_\_\_ severe \_\_\_ moderate \_\_\_ minimal \_\_\_ none \_\_\_ N/A.

I have experienced \_\_\_ nervousness \_\_\_ irritability \_\_\_ fatigue \_\_\_ depression \_\_\_ run down feeling  
\_\_\_ craving for sweets \_\_\_ craving for salts

Does your past history include any hospitalizations or surgeries? Y N If yes, please elaborate on when, where, what, etc. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you: Single Married Divorced Separated Widowed (circle one)



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Do you have any children? Y N If yes, please list their sex and their ages \_\_\_\_\_

Do your children have any major medical problems (past or present)? Y N If yes, please describe \_\_\_\_\_

Do you have any siblings? Y N If yes, please list any major medical problems that are part of your siblings' history \_\_\_\_\_

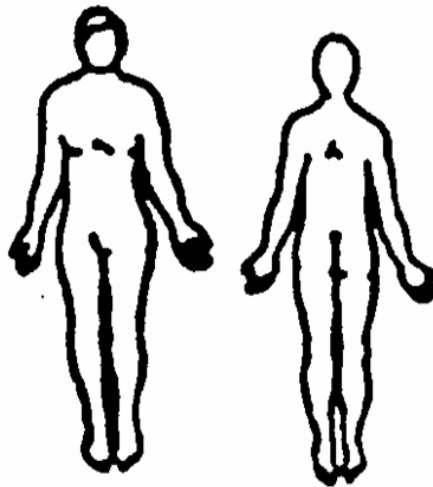
Are your parents still living? Y N Are there any major medical problems (past or present) that are part of your parents' history? Y N If yes, please describe \_\_\_\_\_

Do your maternal or paternal grandparents have any major medical problems (past or present) that are part of their history? Y N If yes, please describe \_\_\_\_\_

1. What type of pain is it? \_\_\_Sharp/Stabbing \_\_\_Ache \_\_\_Dull \_\_\_Burning \_\_\_Throbbing \_\_\_Numbness \_\_\_Tingling \_\_\_Cramping
2. Rate pain on a scale of 0-10 (10 being severe pain): \_\_\_ Average \_\_\_ Better \_\_\_ Worse \_\_\_ Over past week
3. How long have you had this pain? \_\_\_\_\_
4. What makes the pain worse? \_\_\_\_\_
5. What makes the pain better? \_\_\_\_\_
6. Does the pain travel? \_\_\_\_\_ If so, where? \_\_\_\_\_
7. Is pain worse at any particular time of day? \_\_\_\_\_
8. Date of onset \_\_\_/\_\_\_/\_\_\_ Date of same or similar symptoms \_\_\_/\_\_\_/\_\_\_

To help us better understand the nature & origin of your complaints, we ask that you carefully complete this drawing. Use the symbols listed below to detail where you hurt and how it hurts on the figures.

- ////////// Dull Ache/Throb
- XXXXXX Sharp/Stabbing
- BBBBBB Burning
- OOOOOO Numbness
- ..... Tingling
- CCCCCC Cramping



Thank-you for completing this form. The information you have provided will assist us in attending to your health-care needs.

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions, may require me to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a rehabilitation exercise program or care designed for me if determined to be clinically medically necessary by my doctor or therapist. I will notify them of any changes in my health status during the duration of the program. It is also my duty to daily inform the doctor, therapist or assistant of any possible complication prior to the initiation of my daily rehabilitation or treatment.

Your signature \_\_\_\_\_ Date \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_