**Atlas Rehabilitation**

**Vehicle Accident Questionnaire**

Please print clearly and accurate

Name: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M I\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_

Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M/F

Marital status:\_\_\_\_\_\_\_\_ Spouses Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#Children\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_title/duties\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

**Must complete all Blanks**

Your auto insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other vehicle’s insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver of your car\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver of other car\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of adjuster\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Accident Information

**Date of Accident\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_AM/PM** Conditions**:** wet/dry: sunny/darkNo.of passengers\_\_\_\_

Police? WPD\_\_\_DPS\_\_\_ Seat Belt? Yes\_\_\_No\_\_ Shoulder Strap? Yes\_\_No\_\_\_ Head rest? Yes\_\_\_No\_\_\_\_

You were: passenger\_\_\_driver\_\_\_ Air Bag? Yes\_\_\_\_ No\_\_\_\_ Did not deploy\_\_\_\_\_

Front seat\_\_\_ back seat\_\_\_\_ RT/LT/Mid You were struck from: front\_\_\_ rear\_\_\_ right side\_\_\_\_ left side\_\_\_\_

Make/Model of your vehicle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Make/Model of other vehicle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated damage amount to your vehicle $**\_\_\_\_\_\_\_\_\_**

Were you unconscious? Yes\_\_\_\_ NO\_\_\_\_ Were you taken home? Yes \_\_\_\_NO\_\_\_\_

Were you taken to the Hospital? Yes\_\_\_\_NO\_\_\_ Hillcrest ER\_\_\_\_ Providence ER\_\_\_\_SW\_\_ By Amb.\_\_\_\_Car\_\_\_\_\_

You were taken to the Hospital? Immediately\_\_\_\_\_ Hours later #\_\_\_\_\_ Days later #\_\_\_\_\_\_ Drove self? Yes\_\_No\_\_\_

Did you see a Doctor? Yes\_\_\_\_ No\_\_\_ if yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD. DO.

Did you receive ? Exam\_\_\_\_ Xrays\_\_\_\_\_ Cat scan\_\_\_\_ MRI\_\_\_\_\_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you receive any Medicine? Yes\_\_\_\_ No\_\_\_ if yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# WORK INFORMATION

# How long have you been employed at your job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you missed work due to your accident/injury? Yes\_\_\_\_No\_\_\_\_ if yes, \_\_\_\_\_days\_\_\_\_\_wks\_\_\_\_months

Have you returned to work? Yes\_\_\_\_No\_\_\_ if yes, Light duty\_\_\_\_\_\_Regular duty\_\_\_\_\_\_ same job? Yes\_\_\_No\_\_\_

Have you ever been injured on the Job? Yes\_\_\_\_No\_\_\_\_ if yes, when?\_\_\_\_\_\_\_\_\_\_ receive treatment? Yes\_\_\_No\_\_\_

Are you disabled? Yes\_\_\_No\_\_\_ VA\_\_\_\_SSI\_\_\_\_ I am: Retired\_\_\_\_\_Student\_\_\_\_Unemployed\_\_\_\_Part time\_\_\_\_\_

Any prior treatment for this injury? Yes\_\_\_\_ No\_\_\_\_

Are you receiving current care for this condition? Yes\_\_\_\_No\_\_\_\_ If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe accident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Describe Symptoms and location of Injury: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the amount of pain you are in today:

No pain 0 1 2 3 4 5 6 7 8 9 10 severe pain The pain is: worse\_\_\_\_improved\_\_\_\_same\_\_\_\_\_\_

While I am awake, my pain is:

Constant\_\_\_ (76-100%) Frequent\_\_\_\_ (61-75%) Intermittent\_\_\_\_ (26-50%) Occasional\_\_\_\_ (1-25%) of the time.

My pain is: deep/sharp/dull/burning/tingling/stabbing/pulling/drawing/throbbing/piercing/numbness

It is worse when: sitting/standing/bending/sleeping/turning or\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I currently have pain in: neck/mid back /low back/pelvic Arm rt/lt Leg rt/lt Head/ headache Foot/hand

I have: Blurred vision\_\_\_ Ringing In Ears\_\_\_\_ Dizzy\_\_\_\_ Groin pain\_\_\_\_\_ Bladder \_\_\_Bowel\_\_\_\_\_

My condition is better when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ /nothing

Are you pregnant? Yes\_\_\_\_No\_\_\_\_ If yes, How many weeks\_\_\_\_\_ Do you have Allergies? Yes \_\_\_No\_\_\_\_

List Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Fractures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoker? Yes\_\_\_\_NO\_\_\_\_ ½ pk \_\_\_\_PKS Alcohol? frequent\_\_\_\_occasional\_\_\_\_social\_\_\_\_ beer\_\_\_\_hard\_\_\_\_

Education: High school/ GED/College/ grade complete\_\_\_\_ other\_\_\_\_\_\_Have you missed school?\_\_\_\_days\_\_\_\_wks

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ DR.\_\_\_\_\_\_\_init.