Outpatient Rehabilitation Services
Patient Questionnaire – Accident

Name: ___________________________ Date: _______________ Referred by: ___________________________

1. Date of accident: __________________________________________________________

2. □ Driver in vehicle □ Passenger in vehicle □ Pedestrian □ Bicyclist □ Other: ____________

3. Can you describe what happened? ________________________________________________

________________________________________________________________________

________________________________________________________________________

4. Number of vehicles involved: □ One □ More than one (#) _________ □ N/A

5. Did you suffer any physical injuries from the accident? □ Yes □ No
   If yes, please describe: ________________________________________________________

________________________________________________________________________

________________________________________________________________________

6. How would you rate your health before the accident?
   _______ (0 = chronic, interfering health problems, 100 = “super healthy”)

7. How do you rate your health since the accident?
   _______ (0 = chronic, interfering health problems, 100 = “super healthy”)

8. Were other people injured in the accident? □ Yes □ No
   If yes, please describe: ________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
9. Was anyone killed or seriously injured?  □ Yes  □ No
   If yes, please describe: __________________________________________________________
   __________________________________________________________
   __________________________________________________________

10. Did you miss any work/school because of the accident?  □ Yes  □ No
    If yes: (a) How much? ______ (days/weeks)
    (b) Are you still out of work/school?  □ Yes  □ No

11. Was there damage to your vehicle?  □ Yes  □ No
    If yes:  □ Damage estimate $___________  □ Total loss

12. If there was another vehicle, how much damage did it sustain?
    □ Damage estimate $___________  □ Total loss

13. Did you go to the emergency department?  □ Yes  □ No
    If yes, where? ________________________________________________________________

14. When did you first see a physician about your accident?  ____ / ____ (month/year)

15. What doctors or providers have you seen? (List specialty) __________________________
    ____________________________________________________________________________
    ____________________________________________________________________________

16. Were you hospitalized?  □ Yes  □ No
    If yes, for what and for how long? ________________________________________________

17. Are you continuing to have any pain or discomfort from the accident?  □ Yes  □ No
    If yes, please describe: _________________________________________________________
    __________________________________________________________
    __________________________________________________________

18. Are you taking any medication for the pain?  □ Yes  □ No

19. Did you suffer a blow to your head?  □ Yes  □ No
20. Did you suffer any loss of consciousness during the accident?  □ Yes  □ No

If yes, how long?  ________________________________________________________________

21. Have you noticed any changes in memory, ability to multi-task, organize, etc.?  □ Yes  □ No

☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10
No Changes  ________________________________________________________________

22. Do you have headaches as a result of/or since the accident?  □ Yes  □ No

23. What is your estimate of your present functioning?

_______%  (0 = not functioning, 100 = pre-accident functioning)

24. Are you driving at the present time?  □ Yes  □ No

If no, why not?  ________________________________________________________________

If yes, how has your driving/riding been affected by the accident?  ____________________

25. In reference to your present travel, please check all that apply:

☐ Restricted to local driving  ☐ Reluctant to ride in a car
☐ Anxious in congested traffic  ☐ Restrict speed
☐ Avoidance of certain roads  ☐ Avoid pleasure trips, drive to work only
☐ Avoid highway driving  ☐ Not drive at all
☐ Avoid accident area only  ☐ Other ________________________________

26. During, or immediately after the accident were you fearful or afraid?  □ Yes  □ No

How fearful or afraid were you?  _______ (0 = none, 100 = intensely afraid or terrified)

27. Did you have any feelings of helplessness during or immediately after the accident?  □ Yes  □ No

How helpless did you feel?  _______ (0 = not at all, 100 = totally)

28. During the accident, how much danger did you feel that you were in?

_______ (0 = none, 100 = extreme, life threatening)

29. Did you feel as if you might die?

_______ (0 = no, 100 = certain I would die)
30. Have you had any auto accidents in the past?  □ Yes  □ No
   If yes, please describe, giving dates, severity, and circumstances: ____________________________
   ____________________________________________________________
   ____________________________________________________________

31. How vulnerable do you feel now when you drive or are a passenger in a car?
   __________ (0 = none, 100 = extremely)

32. If it was a two-car accident, how culpable do you feel the other driver was?
   __________ (0 = none, 100 = totally)

33. Did you feel responsible for the accident? __________ (0 = not at all, 100 = completely)

34. Were there drugs or alcohol associated with the accident?  □ Yes  □ No
   If yes, please list: _____________________________________________

35. Had you been drinking or using any drug(s) prior to the accident?  □ Yes  □ No
   If yes, were you at all impaired in performance by alcohol or drugs? __________________________

36. Was a traffic ticket issued?  □ Yes  □ No
   If yes, to whom? _____________________________________________

37. Is there any litigation expected or underway as a result of this car accident?  □ Yes  □ No
   If yes, please list lawyer’s name and address: ____________________________
   ____________________________________________________________

38. Any family history of note, either medical or other pain and accident related histories?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

   Patient Signature ___________________________  Date/Time ___________________________

Thank you! Please turn this questionnaire in to the Outpatient Rehabilitation check in desk during the check in process the day of your evaluation.