Boulder Community Health

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: _____

   _____

   _____

_____
Patient Label or Name and DOB

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

_____

Patient Label or Name and DOB

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 Totally Unable to Concentrate

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

_____
Patient Label or Name and DOB

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.

_____

Patient Label or Name and DOB