DELAWARE ORTHOPAEDICS AND SPORTS MEDICINE, PA

Ortho*Ready* Walk-In

Phone: 302-730-0840 • Fax: 302-730-3006

230 Beiser Boulevard • Suite 100 • Dover, Delaware 19904

Auto Accident Questionnaire — Page 1

PLEASE ANSWER ALL OF THE QUESTIONS

1. Please give the date of the auto accident that your current symptoms are related and how the accident happened. Please give details of the accident and describe any damage to the vehicle. _____

   _____

   _____

   _____

   _____

   a. Were you the:..... ❑ Driver ❑ Passenger
   b. If a passenger, were you in the:..... ❑ front ❑ back
   c If in the front did the air bags deploy?..... ❑ YES ❑ NO
   d. Were you the only one injured in the accident? ❑ YES ❑ NO
   e. Were you wearing a seat belt?..... ❑ YES ❑ NO
   f. Did you hit your head or any other part of your body on anything? ..... ❑ YES ❑ NO
      If yes, please describe: _____
   g. Were you unconscious at any time during or after the accident?..... ❑ YES ❑ NO

2. At the time of the accident, what symptoms did you first notice? _____

   _____

   _____

3. Did you go to the hospital at the time of the injury?..... ❑ YES ❑ NO
   If yes, which hospital?_____
   If you went to the E.R., do you remember who treated you?..... ❑ YES ❑ NO
   If yes, please list:_____
   If no, did you go to the hospital or seek medical treatment at any time following the injury? ❑YES ❑NO
   If yes, where and when did you seek treatment? _____

4. Since the initial injury, has your pain changed in any way?..... ❑ YES ❑ NO
   If yes, please describe:_____
   Did you notice or develop any other pain after the initial injury?... ❑ YES ❑ NO
   If yes, please describe:_____

5. Is there anything that you do that seems to make the pain any better?_____

   _____

6. Are there any activities that aggravate the pain? _____

   _____

7. Do you have any numbness or tingling? ❑ YES ❑ NO If yes, where?_____
   a. Does the numbness or tingling go into your arms, hands, legs, or feet? ❑ YES ❑ NO
   b. Is it in the: ❑ right ❑ left ❑ both extremities
   c. Has it gotten better, worse, or stayed the same since the accident? _____

PLEASE TURN OVER AND COMPLETE ALL OF THE QUESTIONS ON THE BACK.

8. Is the pain worse in the: ❑ Daytime ❑ Nighttime
   a. Do you wake at night time with pain or numbness? ❑ YES ❑ NO If yes, where? _____
   b. Is it on a daily basis, or how often do you notice it? _____

9. What position is the best? ❑ Sitting ❑ Standing ❑ Lying down

10. Do you have any problems with your bowels or bladder? ❑ YES ❑ NO
    If yes, please describe: _____

11. Are you on any medications? ❑ YES ❑ NO If yes, please list them: _____
    _____

12. What type of work do you do? _____

13. Have you been working since the accident? ❑ YES ❑ NO

14. If you have been working, have you been doing your regular job or some type of modified duty? _____
    _____

15. Have you ever been injured in an auto accident before? ❑ YES ❑ NO
    If yes, please give the date(s) of previous accident(s): _____

16. If you have been involved in a prior auto accident, please give the date of the injury, describe the injuries sustained, and what type of treatment was involved. _____
    _____
    _____

17. Have you ever been injured at work or had a condition that was related to your job activities? ❑YES ❑NO
    If yes, please give the date(s) of injury, and describe the injury or condition and type of treatment received? _____

18. Did all of your symptoms completely resolve prior to this accident? ❑ YES ❑ NO
    If no, please explain: _____

19. I am aware if my PIP (personal injury protection - the amount of money your insurance company will pay for your medical expenses) runs out I will be responsible for any remaining balance due. Do you have back up medical insurance in case your PIP runs out? ❑ YES ❑ NO
    If yes, please present your back up insurance cards to the receptionist.

I certify that the information on both pages of this document is true and correct to the best of my knowledge.

_____ _____
Signature Date

*This form expires 1 year from the signature date.
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