ACCIDENT / INJURY QUESTIONNAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** form.

Patient Name:

MO	DAY	YEAR
1 7	1	0
2 8	2 10	1
3 9	3 20	2
4 10	4 30	3
5 11	5 40	4
6 12	6 50	5
	10 7 60	6
	20 8 70	7
	30 9 80	8
	90	9

DR# | PATIENT NUMBER (bubbles 0–9 per digit)

A. DATE AND TIME OF ACCIDENT / INJURY

Date: / / Time: : am / pm

B. DESCRIPTION OF ACCIDENT / INJURY

- Automobile Accident Questionnaire Marked **(Skip Section B)**
- Workmen's Compensation Accident / Injury
- Slip/Fall Accident
- Pedestrian Accident

Other: Accident Injury

1. What was the cause of your accident / injury?

2. Describe in your own words what happened:

C. IMMEDIATELY AFTER ACCIDENT / INJURY

1. Did you lose consciousness?

Yes No Don't Know

2. How did you feel?

Confused Dazed Dizzy Nervous
Weak Other

3. Where did you immediately develop pain?

Head	R L Shoulders	R L Buttocks
Neck	R L Arms	R L Hips
Upper / Mid Back	R L Elbows	R L Thighs
Lower Back	R L Forearms	R L Knees
Pelvis	R L Wrists	R L Legs
Chest / Rib Cage	R L Hands	R L Ankles
Abdomen		R L Feet
Other		

4. If there were lacerations (cuts), where were they?

Head	R L Shoulders	R L Buttocks
Neck	R L Arms	R L Hips
Upper / Mid Back	R L Elbows	R L Thighs
Lower Back	R L Forearms	R L Knees
Pelvis	R L Wrists	R L Legs
Chest / Rib Cage	R L Hands	R L Ankles
Abdomen		R L Feet
Other		

5. Describe any other significant injury:

6. Emergency Care At Accident/Injury Site

a. Did you receive emergency care? Yes No

b. What type of emergency care did you receive?
Bandages Splints Brace Neck Collar
Other

7. Destination After Accident / Injury

a. Where did you go?
Hospital Home
School Work
Other

b. By whom were you driven?
Myself Ambulance
Friend Family Member
Other

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

1. When did you go to the hospital?

Immediately Later That Day Next Day Days Later
Date / / Other

Hospital Name:

Examined By Doctor:

Admitted: Yes No

Date Discharged: / /

2. If x-rays were taken, of what body part(s)?

Head	R L Shoulders	R L Buttocks
Neck	R L Arms	R L Hips
Upper / Mid Back	R L Elbows	R L Thighs
Lower Back	R L Forearms	R L Knees
Pelvis	R L Wrists	R L Legs
Chest / Rib Cage	R L Hands	R L Ankles
Abdomen		R L Feet
Other		

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D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

3. If a CAT Scan was performed, of what body part(s)?

- Head
- Upper / Mid Back
- Chest / Rib Cage
- Neck
- Lower Back
- Abdomen
- Other

4. If a MRI was performed, of what body part(s)?

- Head
- Upper / Mid Back
- Chest / Rib Cage
- Neck
- Lower Back
- Abdomen
- Other

5. What was the diagnosis given at the hospital?

a. Head
- Concussion
- Skull Fracture
- Lacerations
- Contusions
- Other

b. Jaw
- Strain
- Sprain
- Dislocation
- Fracture
- Whiplash
- Lacerations
- Contusions
- Other

c. Neck
- Strain
- Sprain
- Dislocation
- Fracture
- Whiplash
- Disc Injury
- Lacerations
- Contusions
- Other

d. Upper / Middle Back
- Strain
- Sprain
- Dislocation
- Fracture
- Disc Injury
- Lacerations
- Contusions
- Other

e. Lower Back
- Strain
- Sprain
- Dislocation
- Fracture
- Disc Injury
- Lacerations
- Contusions
- Other

f. Pelvis
- Strain
- Sprain
- Dislocation
- Fracture
- Lacerations
- Contusions
- Other

g. Chest / Rib Cage
- Strain
- Sprain
- Dislocation
- Fracture
- Lacerations
- Contusions
- Other

h. Abdomen
- Strain
- Lacerations
- Contusions
- Other

i. Shoulders
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

j. Arms
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

k. Elbows
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

l. Forearms
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

m. Wrists
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

n. Hands / Fingers
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

o. Buttocks
- R L Strain
- R L Sprain
- R L Lacerations
- R L Contusions
- R L Other

p. Hips
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

q. Thighs
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

r. Knees
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

s. Legs
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

t. Ankles
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

u. Feet / Toes
- R L Strain
- R L Sprain
- R L Dislocation
- R L Fracture
- R L Lacerations
- R L Contusions
- R L Other

v. Other
- Strain
- Sprain
- Dislocation
- Fracture
- Lacerations
- Contusions

w. Describe any additional diagnosis given:

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D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

- ⬭ Oral Medication ⬭ Sutures ⬭ Splint ⬭ Collar
- ⬭ Injection ⬭ Ice Packs ⬭ Cast ⬭ Support
- ⬭ Topical Antiseptics ⬭ Hot Packs ⬭ Brace ⬭ Surgery
- ⬭ Bandages ⬭ Other ________

7. Instructions Given When Discharged From Hospital

a. Were you told to see?

- ⬭ General Practitioner ⬭ Chiropractor ⬭ Neurologist
- ⬭ Physical Therapist ⬭ Orthopedist ⬭ Internist
- ⬭ General Surgeon ⬭ Plastic Surgeon ⬭
- ⬭ Other ________

b. What recommendations were made?

- ⬭ No Further Care ⬭ No Follow-up Instructions ⬭ Observation
- ⬭ Rest ⬭ Ice ⬭ Heat ⬭ Collar ⬭ Support
- ⬭ Time Off Work ⬭ Other ________

c. Were medications prescribed?

- ⬭ Pain ⬭ Anti-inflammatory ⬭ Antibiotic ⬭ Nervousness
- ⬭ Other ________

E. FOLLOWING THE ACCIDENT / INJURY

1. How much later did additional symptoms develop?

- ⬭ Immediately ⬭ Hours ⬭ That Evening ⬭ Next Morning
- ⬭ Days ⬭ Week ⬭ Month ________

2. What additional symptoms developed?

a. Head
⬭ Pain ⬭ Stiffness ⬭ Numbness ⬭ Tingling
⬭ Other ________

b. Jaw
⬭ Pain ⬭ Stiffness ⬭ Numbness ⬭ Tingling
⬭ Other ________

c. Neck
⬭ Pain ⬭ Stiffness ⬭ Numbness ⬭ Tingling
⬭ Other ________

d. Upper / Middle Back
⬭ Pain ⬭ Stiffness ⬭ Numbness ⬭ Tingling
⬭ Other ________

e. Lower Back
⬭ Pain ⬭ Stiffness ⬭ Numbness ⬭ Tingling
⬭ Other ________

f. Pelvis
⬭ Pain ⬭ Stiffness ⬭ Numbness ⬭ Tingling
⬭ Other ________

g. Chest / Rib Cage
⬭ Pain ⬭ Stiffness ⬭ Numbness ⬭ Tingling
⬭ Other ________

h. Abdomen
⬭ Pain ⬭ Stiffness ⬭ Numbness ⬭ Tingling
⬭ Other ________

i. Shoulders
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

j. Arms
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

k. Elbows
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

l. Forearms
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

m. Wrists
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

n. Hands / Fingers
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

o. Buttocks
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

p. Hips
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

q. Thighs
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

r. Knees
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

s. Legs
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

t. Ankles
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

u. Feet / Toes
Ⓡ Ⓛ Pain Ⓡ Ⓛ Stiffness Ⓡ Ⓛ Numbness Ⓡ Ⓛ Tingling
Ⓡ Ⓛ Other ________

v. Other ________ ⬭ ________

3. Since your accident / injury have you suffered from?

- ⬭ Blurred Vision ⬭ Chest Pain ⬭ Nausea
- ⬭ Double Vision ⬭ Difficulty Breathing ⬭ Vomiting
- ⬭ Reduced Vision ⬭ Palpitations ⬭ Frequent Urination
- ⬭ Impaired Hearing ⬭ Constipation ⬭ Inability To Hold Urine
- ⬭ Ringing In Ears ⬭ Diarrhea ⬭ Painful Urination

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E. FOLLOWING THE ACCIDENT/INJURY (Continued)

4. Additionally have you experienced any of the following?

- ⬭ Anxiety
- ⬭ Convulsions
- ⬭ Restlessness
- ⬭ Depression
- ⬭ Dizziness
- ⬭ Insomnia
- ⬭ Mood Swings
- ⬭ Headaches
- ⬭ Light Sensitivity
- ⬭ Nervousness
- ⬭ Fainting
- ⬭ Reduced Appetite
- ⬭ Poor Memory
- ⬭ Loss Of Balance
- ⬭ Weakness
- ⬭ Tension
- ⬭ Fatigue
- ⬭ Weight Gain
- ⬭ Other
- ⬭ Weight Loss

5. Are you restricted in any of the following areas as a

- ⬭ Daily Living
- ⬭ Occupational/Work
- ⬭ Recreational Activities
- ⬭ Other

6. Have you missed work due to this accident / injury?

- ⬭ Missed No Work
- ⬭ Limited Work Activity
- ⬭ Missed Work From: / / To: / /
- ⬭ Other

7. Did you self treat your symptoms?

- ⬭ Ice
- ⬭ Heat
- ⬭ Bed Rest
- ⬭ Over-The-Counter Medication
- ⬭ Other

8. Did you seek medical care elsewhere?

a. General Practitioner ⬭ Name:

⬭ Diagnosis And Treatment Recommendation:

b. Internist ⬭ Name:

⬭ Diagnosis And Treatment Recommendation:

c. Chiropractor ⬭ Name:

⬭ Diagnosis And Treatment Recommendation:

d. Neurologist ⬭ Name:

⬭ Diagnosis And Treatment Recommendation:

e. Orthopedist ⬭ Name:

⬭ Diagnosis And Treatment Recommendation:

f. General Surgeon ⬭ Name:

⬭ Diagnosis And Treatment Recommendation:

g. Plastic Surgeon ⬭ Name:

⬭ Diagnosis And Treatment Recommendation:

h. Psychologist ⬭ Name:

⬭ Diagnosis And Treatment Recommendation:

i. Other ⬭ Name: ⬭ Type:

⬭ Diagnosis And Treatment Recommendation:

9. Have you had any of the following tests?

- ⬭ CT Scan
- ⬭ MRI
- ⬭ Electrodiagnostic Studies
- ⬭ Other

10. What is the reason for seeking today's consultation?

- ⬭ Persisting Complaints
- ⬭ Worsening Of Symptoms
- ⬭ Other

F. INSURANCE / ATTORNEY INFORMATION

	Yes	No
1. Have you contacted an insurance adjuster or representative regarding this claim? Company: Adjuster: Claim #:	Y	N
2. Have you engaged services of an attorney? Attorney: Address: City: State: Zip: Phone:	Y	N
3. Have you filed an accident / injury report?	Y	N
4. Have you filed for insurance benefits?	Y	N

Patient's Or Guardian Signature: **Date:**

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