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	DR#	PATIENT NUMBER

A. DATE AND TIME OF ACCIDENT / INJURY

○ Date: / / Time: : am / pm

B. DESCRIPTION OF ACCIDENT / INJURY

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

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

○ Head	®Ⓛ Shoulders	®Ⓛ Buttocks
○ Neck	®Ⓛ Arms	®Ⓛ Hips
○ Upper / Mid Back	®Ⓛ Elbows	®Ⓛ Thighs
○ Lower Back	®Ⓛ Forearms	®Ⓛ Knees
○ Pelvis	®Ⓛ Wrists	®Ⓛ Legs
○ Chest / Rib Cage	®Ⓛ Hands	®Ⓛ Ankles
○ Abdomen		®Ⓛ 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	®Ⓛ Shoulders	®Ⓛ Buttocks
○ Neck	®Ⓛ Arms	®Ⓛ Hips
○ Upper / Mid Back	®Ⓛ Elbows	®Ⓛ Thighs
○ Lower Back	®Ⓛ Forearms	®Ⓛ Knees
○ Pelvis	®Ⓛ Wrists	®Ⓛ Legs
○ Chest / Rib Cage	®Ⓛ Hands	®Ⓛ Ankles
○ Abdomen		®Ⓛ 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
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

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

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

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

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

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

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

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

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

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

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

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

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

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

w. Describe any additional diagnosis given:

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

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

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

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 result of this accident/injury?

○ 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)

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

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