Accident/Injury Questionnaire

This questionnaire will allow you to describe your accident or injury in detail Please compete it carefully as the information you provide will assist the doctor in evaluation and documentation your condition. THANK YOU.

Patient Name_______________________________ DOB__________

Date of Injury__________________ Time of injury____________________

Description: (circle on)

Workmen's compensation accident/ injury	Slip/fall accident
Pedestrian accident	Other Accident/Injury

What was the cause of you accident or injury?

____
____
____

Describe in you own words what happened:

____
____
____

Immediately after the accident/ Injury

1) Did you lose consciousness? Y N

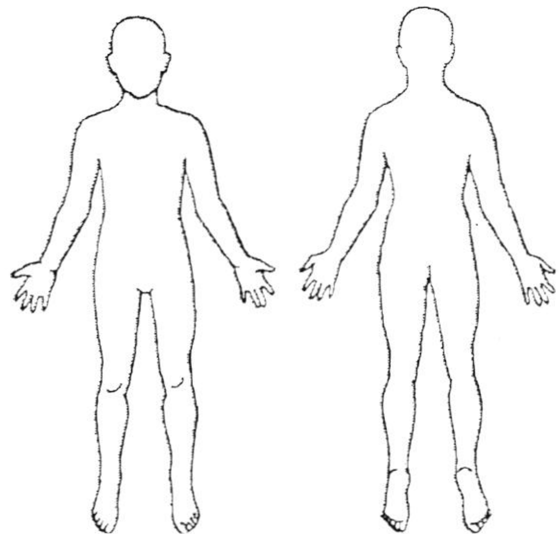
2) How did you feel? (Circle one)
Confused dazed dizzy nervous weak
Other ______________________________

3) Where did you immediately develop pain?

Mark an X on the picture:

Describe:

____
____
____
____
____



4) Of there were Lacerations (cuts), where were they?
Describe:

____
____
____

5) Did you receive emergency care? Y N

6) Was there emergency care on site? Y N

7) Destination after accident

Where did you go? Hospital Home
School Work
Other___________________

Who drove you? Myself Ambulance
Friend Family Member
Other___________________

Hospital Visit after Accident/ Injury

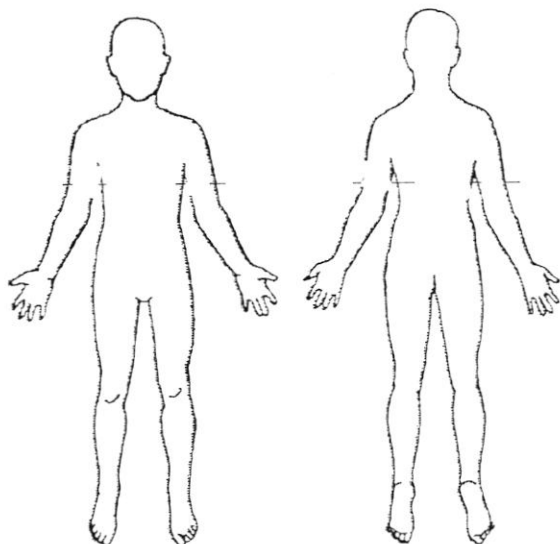
1) When did you go to the hospital? Date_______________

Immediately Later that day Next Day Days later

Admitted: Y N

Date Discharged: ________________

2) If x-rays, CAT Scan, or MRI were taken, where?



Mark on the picture:

X for X-ray
C for CAT Scan
M for MRI

Describe:

____
____
____
____
____

3) What was the diagnosis given at the hospital?

Example: Sprain/strain of the neck/ back: left or right side
Dislocation/Fracture of the shoulder/hip: left or right side
Cut/Contusion of the abdomen/leg: left or right side

Description:

____
____
____
____
____
____

4) What treatment was administered at the hospital? (Circle one)

Oral medication	sutures	splint	collar	injection
Ice Pack	Cast	Support	Topical Antiseptics	
Hot Pack	Brace	Surgery	Bandages	

Other ____________________

5) When discharged from the hospital, were you told to see a? (Circle one)

General Practitioner	Chiropractor	Neurologist	Physical therapist
Orthopedist	Internist	General Surgeon	Plastic Surgeon

6) What recommendations were made? (Circle one)

No further care	No follow up instructions	Observation	Rest
Ice	Heat	Collar Support	Time off work

Other ____________________

7) Where any medications were prescribed? (Circle one)

Pain	Anti- Inflammatory	Antibiotic	Nervousness

Other ____________________

Following the Accident/ Injury

1) How much later did additional symptoms develop?

Immediately	Hours	That evening	Next Morning
Days	Week	Month	Other ________

2) What additional Symptoms Developed?

Example: Neck/ Back Pain/Numbness on the left or right side

Chest/ Thigh Stiffness/Tingling on the left or right side

Description:

____

____

____

____

____

____

3) Since your accident/ injury have you suffered from? (Circle one)

Blurred vision	chest pain	nausea
Double vision	Difficult Breathing	Vomiting
Reduced Vision	Palpations	Frequent Urination
Impaired Hearing	Constipation	Inability to hold Urine
Ringing In ears	Diarrhea	Painful Urination
Other ________		None of the Above

4) Additionally, Have you experienced any of the following?

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

Other ____________________

5) Are you restricted in any of the following areas as â result of this accident/injury?
Daily Living Occupational/Work Recreational Activities
Other ____________________

6) Are you missing work due to this accident/injury? Y N
Dates missed: ____________________

7) Did you self treat your symptoms?
Ice Heat Bed rest over -the -counter Medication
Other: ____________________

8) Did you seek medical care elsewhere?
Where: ____________________
____
____

9) Have you had any of the following tests?
CT Scan MRI Elect -diagnostic Studies
Other ____________________

10) What is the Reason for seeking today's Consultation?
Persistent complaints Worsening of symptoms
Other

Insurance/ Attorney Information:

1) Have you contacted an insurance adjuster or representative regarding this claim? Y N
Company: ____________________
Adjuster: ____________________
Claim #: ____________________

2) Have you engaged services of an attorney? Y N
Attorney: ____________________
Address: ____________________
____
Phone#: ____________________

3) Have you filed and accident/ injury report? Y N

4) Have you filed for insurance benefits? Y N

Patients Signature ____________________ Date