PATIENT ACCIDENT QUESTIONNAIRE

Name:______________________________ Date:________________

Date of Accident:_________________
Type of Accident: Motor Vehicle / Workers Compensation / Other ___________________

Describe in Detail your accident: ____
____
____
____
____

What part(s) of your body was injured:
____
____
____

If Injuries were related to a motor vehicle accident:
Were you the Driver ____ Passenger:___ Were you in the Front seat: ___ Back seat: ___
Were you seat belted? Yes ____ No _____ Did an airbag deploy? Yes ____ No _____

Immediately after the accident did you experience any of the following: (Check all that apply):

____ Bleeding (Where?) __________
____ Unconsciousness (How long?) _____
____Neck Pain
____Leg Pain
____Numbness (Where?) __________
____ Bruising (Where?) ______________
____ Headaches
____ Back Pain
____ Arm Pain
____ Tingling (Where?) ______________

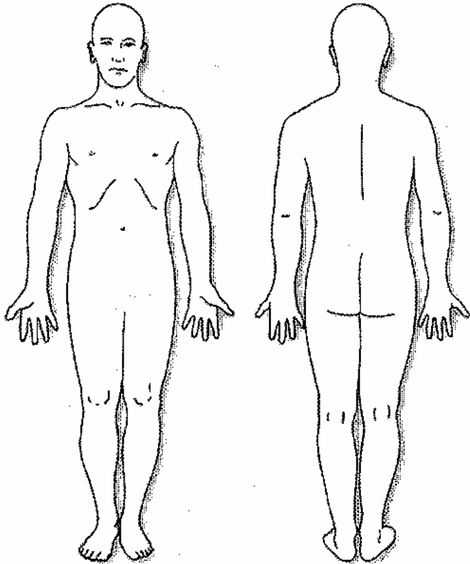
Please describe any other symptoms you experienced immediately following your accident.____
____

Were you walking at the scene of the accident? Yes / No
Did you go to the emergency room? Yes / No
What date? ___________ Which emergency room?_________________
How did you get to the emergency room? ____
Were studies performed: Please check: X-rays ____ CAT scan _____ MRI ______
What were the results of the studies: ____
What type of treatment did you receive: ____
Were you admitted to the hospital? Yes / No For how long? ________________

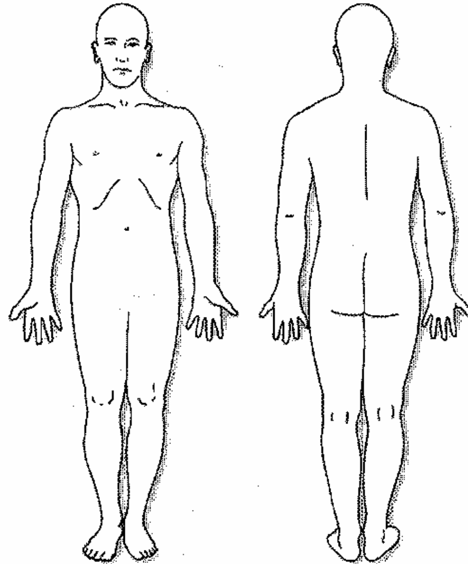
Are you experiencing any of the following symptoms now (Check all that apply):

____ Headaches
____Neck Pain ____ Back Pain
____Leg Pain ____ Arm Pain
____Numbness (Where?) _________ ____ Tingling (Where?) _____________
____Changes in Bowel or Bladder function ____Trouble walking

Using the diagram below, darken the areas where you experienced pain immediately following your accident:



Using the diagram below, darken the areas where you are experiencing pain now.



Mark with an "X" the areas that cause the most pain or discomfort.

Have you been treated by any other doctor's regarding this accident? Yes / No

I Doctor's name _________________________ Specialty: ______________________________
Date of first visit: _________________ Date of last visit: ________________________
What treatment / medication did you receive: _____________________________________
____
How often have you seen this doctor? _________ Are you still seeing this doctor? Yes / No

II Doctor's name _________________________ Specialty: ______________________________
Date of first visit: _________________ Date of last visit: ________________________
What treatment / medication did you receive: _____________________________________
____
How often have you seen this doctor? _________ Are you still seeing this doctor? Yes / No

III Doctor's name _________________________ Specialty: ______________________________
Date of first visit: _________________ Date of last visit: ________________________
What treatment / medication did you receive: _____________________________________
____
How often have you seen this doctor? _________ Are you still seeing this doctor? Yes / No

Is there anything that has made your pain / symptoms **better?**(ex: rest, physical therapy, medicine)
____
____

Is there anything that has made your pain / symptoms **worse?**(ex: walking, lifting)
____
____

What treatments have you had for your injury (Check all that apply)?

____ Physical Therapy ______ Chiropractor Therapy ______ Steroid Injections
____ Facet Blocks ______ Nerve Blocks ______ Back / Neck Brace
____ Traction ______ Acupuncture

Please list any medications that you have taken for this injury (pain meds, muscle relaxants, etc.)
____

What treatments / medications were most beneficial? ______________________________
____

What treatments / medications were least beneficial? ______________________________
____

What studies did you bring with you to today's exam? ______________________________
____

What is your occupation? ____
Please describe what functions / activities you perform at your job: ____________________
____
Are you currently working? Yes / No What date did you last work? ________________
Are you involved in any litigation regarding your injury? Yes / No
Has the case been settled? Yes / No

Have you filed any other workers compensation or motor vehicle injuries prior to the above mentioned claim? Yes / No
If Yes, please complete the following for all injuries **prior to** the above mentioned case:

#1 Date:____________ Injuries Sustained:______________________________
____
Treatment received (if any):____
____
____

#2 Date:____________ Injuries Sustained:______________________________
____

Treatment received (if any):____
____
____

#3 Date:____________ Injuries Sustained:______________________________
____
Treatment received (if any):____
____
____

#4 Date:_______________ Injuries Sustained:____
____
Treatment received (if any):____
____
____

If more than four previous claims have been filed please indicate the number of claims and the date(s) of injury for each:____
____
____

I affirm that the above information provided is true and correct to the best of my knowledge.

____ ____________________
Patient's Signature **Date**