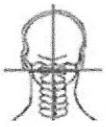


ACCIDENT/INJURY QUESTIONNAIRE

Please complete the following questions regarding your accident. Please complete this form carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU!

Patient Name: _____

Date: _____ ID#: _____

Date: _____ Time: _____ am / pm

(Of the Accident)

DESCRIPTION OF ACCIDENT / INJURY

- ☐ Automobile Crash Questionnaire Marked
- ☐ Workmen's Compensation Accident / Injury
- ☐ Slip / Fall Accident
- ☐ Pedestrian Accident

Other: ☐ Accident ☐ Injury: _____

What was the cause of your accident / injury?

_____

_____

_____

_____

Describe in your own words what happened:

_____

_____

_____

_____

Did you lose consciousness?

☐ Yes ☐ No ☐ Don't Know

Describe any other significant injury:

_____

_____

_____

Did you receive emergency care at the accident site?

☐ Yes ☐ No

How did you feel?

☐ Confused ☐ Dazed ☐ Dizzy ☐ Nervous ☐ Weak

☐ Other: _____

If yes, what type of care did you receive?

_____

_____

Where did you immediately develop pain?

_____

_____

Where did you go after the accident?

_____

_____

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

_____

_____

By whom were you driven?

_____

HOSPITAL VISIT AFTER ACCIDENT / INJURY

When did you go to the hospital?

☐ Immediately ☐ Later That Day ☐ Next Day

☐ Days Later ☐ Date: _____

☐ Other: _____

Hospital Name: _____

Doctor's Name: _____

What procedures were performed?

☐ X-rays Body Part(s): _____

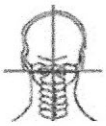
☐ CAT Scan Body Part(s): _____

☐ MRI Body Part(s): _____

What was the diagnosis given at the hospital?

- ☐ Head _____
- ☐ Jaw _____
- ☐ Neck _____
- ☐ Upper / Middle Back _____
- ☐ Lower Back _____
- ☐ Pelvis _____
- ☐ Chest / Rib Cage _____
- ☐ Abdomen _____
- ☐ Shoulders _____
- ☐ Arms _____
- ☐ Elbows _____
- ☐ Forearms _____
- ☐ Wrists _____
- ☐ Hands / Fingers _____
- ☐ Buttocks _____
- ☐ Hips _____
- ☐ Thighs _____
- ☐ Knees _____
- ☐ Legs _____
- ☐ Ankles _____
- ☐ Feet / Toes _____
- ☐ Other _____

Patient Initials: _____



ACCIDENT/INJURY QUESTIONNAIRE

HOSPITAL VISIT AFTER ACCIDENT / INJURY

What treatment was administered at the hospital? _____

Who were you told to see upon discharge from hospital (i.e., General Practitioiner, Chiropractor, Neurologist, etc.)?

_____

What recommendations were made? _____

What medications were prescribed? _____

FOLLOWING THE ACCIDENT / INJURY

How much later did additional symptoms develop? _____

What additional symptoms developed?

_____ ☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Other _____

_____ ☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Other _____

_____ ☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Other _____

_____ ☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Other _____

_____ ☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Other _____

Since your accident / injury have you suffered from:

☐ Blurred Vision	☐ Chest Pain	☐ Nausea
☐ Double Vision	☐ Difficulty Breathing	☐ Vomiting
☐ Reduced Vision	☐ Palpitations	☐ Frequent Urination
☐ Impaired Vision	☐ Constipation	☐ Inability to Hold Urine
☐ Ringing in Ears	☐ Diarrhea	☐ Painful Urination

Additionally have you experienced any of the following?

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

Are you restricted in any of the following as a result of this accident / injury?

☐ Daily Living ☐ Occupational / Work ☐ Recreational Activities ☐ Other _____

Have you missed work due to this accident / injury? ☐ No ☐ Yes From: _____ to _____

Did you self treat your symptoms? ☐ Ice ☐ Heat ☐ Bed Rest ☐ Over-the-Counter Medication ☐ Other _____

Did you seek medical care elsewhere? If yes, please identify where and with whom:

_____ Specialty: _____

_____ Diagnosis / Recommendations: _____

_____ _____

_____ Specialty: _____

_____ Diagnosis / Recommendations: _____

_____ _____

_____ Specialty: _____

_____ Diagnosis / Recommendations: _____

_____ _____

Have you had any additional tests? _____

What is the reason for seeking today's consultation? _____

_____

Signature: _____