AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____

Patient _____ No. _____

Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____

Who referred you to our office? _____

Social Sec. # _____ Business Phone _____ Company Name _____

Company Address _____

Please explain in detail how your accident happened? _____

_____

_____

Driver of other vehicle (if any) _____ Date of Birth _____

Insurance Company _____ Address _____ Phone No: _____

Policy No. _____

Claim No. _____

Name of person who has made contact with you _____

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company _____ Address _____ Phone No: _____

Policy No. _____

Claim No. _____

Name of Person who has made contact with you _____

Have you retained an attorney? ❑ Yes ❑ No ❑ Not Yet

If so, his/her name, address & phone # _____

Give time and date present injury occurred _____ ❑ AM ❑ PM ____/____/____

You were heading? ❑ North ❑ South ❑ East ❑ West on _____ (street or highway)

Number of people in your vehicle _____

Were police notified? ❑ Yes ❑ No Did head strike windshield or object? ❑ Yes ❑ No

Were you knocked unconscious ❑ Yes ❑ No If so, for how long _____

You were struck from? ❑ Behind ❑ Front ❑ Left Side ❑ Right Side

You were? ❑ Driver ❑ Passenger ❑ Front seat ❑ Back seat ❑ Using seat belts ❑ Other protective devices

Did you feel pain immediately after the accident? ❑ Yes ❑ No ❑ Later that day ❑ Next day ❑ When _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

Was treatment given? _____

Was any doctor consulted after the accident? ❑ Yes ❑ No

If so, give doctor's name _____ ❑ D.C., ❑ M.D., ❑ D.O., ❑ D.D.S. _____

Doctor's Diagnosis _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since the injury, are your symptoms ❑ Improving? ❑ Getting worse? ❑ The same?

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ **No.:** _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones*
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

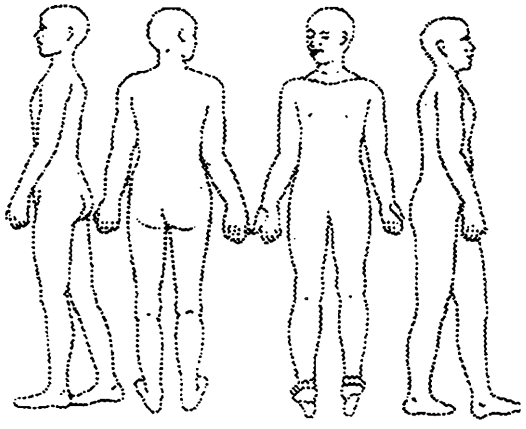
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm
T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Drug Abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

Patient's Signature _____

DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

Patient Accepted? ❑ Yes ❑ No Doctor's Signature _____