1. Accident / Injury Questionnaire

Title: ___________________________ First: ___________________________ MI: __________ Last: ___________________________

Date of accident: ___________________________ Time of accident: ________:_______ am / pm

Type of accident:
☐ Automobile Accident (skip to next section and fill out Auto Accident Questionnaire)
☐ Worker’s Compensation Accident/Injury
☐ Slip/Fall Accident
☐ Pedestrian Accident
☐ Other Accident: ___________________________  ☐ Other Injury: ___________________________

What was the cause of your accident / injury: ________________________________________________________________

Describe in your own words what happened: ________________________________________________________________

_________________________________________________________

2. Immediately After Accident / Injury

Did you lose consciousness?  ☐ Yes  ☐ No  ☐ Unknown

How did you feel (check all that apply):
☐ Confused  ☐ Dazed  ☐ Dizzy  ☐ Nervous  ☐ Weak  ☐ Other: __________

Where did you immediately develop PAIN (○) or have lacerations/CUTS (□) (check all that apply):

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<td>Chest/Rib Cage</td>
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<td>Arms</td>
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<td>Abdomen</td>
<td>Shoulders</td>
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Describe any other significant injury: ________________________________________________________________

_________________________________________________________

Did you receive emergency care at the accident/injury site?  ☐ No  ☐ Yes—(please check all that apply):
☐ Bandages  ☐ Splints  ☐ Brace  ☐ Neck Collar  ☐ Other: ________________________________________

After the accident/injury, where did you go?
☐ Hospital  ☐ Home  ☐ School  ☐ Work  ☐ Other: ________________________________________

By whom were you driven?
☐ Myself  ☐ Friend  ☐ Family  ☐ Ambulance  ☐ Other: ________________________________________
3. Hospital Visit After Accident / Injury

When did you go to the hospital?  [ ] Immediately  [ ] Later That Day  [ ] Next Day  [ ] Days Later  [ ] Other: ___________________________  [ ] Never (skip to section 4 on next page)

Hospital name: ___________________________________________  Examined by doctor: ___________________________________________

X-rays were taken of what body part/s:

- [ ] Head
- [ ] Neck
- [ ] Upper/Mid Back
- [ ] Lower Back
- [ ] Pelvis
- [ ] Abdomen
- [ ] Shoulders
- [ ] Chest/Rib Cage
- [ ] Arms
- [ ] Elbows
- [ ] Forearms
- [ ] Wrist
- [ ] Hands
- [ ] Buttocks
- [ ] Hips
- [ ] Thighs
- [ ] Knees
- [ ] Legs
- [ ] Ankles
- [ ] Feet
- [ ] Other: ___________________________________________

[ ] No x-rays taken

A CAT scan was performed on what body part/s:

- [ ] Head
- [ ] Neck
- [ ] Upper/Mid Back
- [ ] Lower Back
- [ ] Chest/Rib Cage
- [ ] Abdomen
- [ ] Shoulders
- [ ] Chest/Rib Cage
- [ ] Other: ___________________________________________

[ ] No CAT scan

A MRI was performed on what body part/s:

- [ ] Head
- [ ] Neck
- [ ] Upper/Mid Back
- [ ] Lower Back
- [ ] Chest/Rib Cage
- [ ] Abdomen
- [ ] Shoulders
- [ ] Chest/Rib Cage
- [ ] Other: ___________________________________________

[ ] No MRI

What was the diagnosis given at the hospital (describe location on body):

- [ ] Concussion: ___________________________
- [ ] Whiplash: ___________________________
- [ ] Disc Injury: ___________________________
- [ ] Dislocation: ___________________________
- [ ] Fracture: ___________________________
- [ ] Sprain: ___________________________
- [ ] Strain: ___________________________
- [ ] Laceration: ___________________________
- [ ] Contusions: ___________________________

Describe any additional diagnosis given: ___________________________________________

What treatment was administered at the hospital?

- [ ] Oral Medication
- [ ] Sutures
- [ ] Splint
- [ ] Collar
- [ ] Injection
- [ ] Ice Packs
- [ ] Cast
- [ ] Support
- [ ] Brace
- [ ] Surgery
- [ ] Hot Packs
- [ ] Bandages
- [ ] Antiseptics
- [ ] Other: ___________________________  [ ] No Treatment

Upon discharge, whom were you told to see?

- [ ] General Practitioner
- [ ] Chiropractor
- [ ] Neurologist
- [ ] Physical Therapist
- [ ] Orthopedist
- [ ] Internist
- [ ] General Surgeon
- [ ] Plastic Surgeon
- [ ] Other: ___________________________  [ ] No one

Upon discharge, what recommendations were made?

- [ ] Rest
- [ ] Ice
- [ ] Heat
- [ ] Collar
- [ ] Support
- [ ] Time off work
- [ ] Other: ___________________________  [ ] No further care  [ ] No recommendations

Upon discharge, what medications were prescribed?

- [ ] Pain
- [ ] Anti-inflammatory
- [ ] Antibiotics
- [ ] Nervousness
- [ ] Other: ___________________________  [ ] No medications
### 4. Following the Accident / Injury

**How much later did additional symptoms develop?**
- [ ] Immediately
- [ ] Hours
- [ ] That Evening
- [ ] Next Morning
- [ ] Days
- [ ] Week
- [ ] Month
- [ ] Other: ________________________________
- [ ] No other symptoms

**What additional symptoms developed?**

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**Pain**
- Burning
- Numbness
- Soreness
- Stiffness
- Swelling
- Tingling
- Weakness

**Since your accident/injury, have you suffered from:**
- [ ] Blurred Vision
- [ ] Double Vision
- [ ] Vision Trouble
- [ ] Hearing Trouble
- [ ] Ear Ringing
- [ ] Chest Pain
- [ ] Breathing Trouble
- [ ] Palpitations
- [ ] Constipation
- [ ] Diarrhea
- [ ] Nausea
- [ ] Vomiting
- [ ] Frequent Urination
- [ ] Painful Urination
- [ ] Incontinence
- [ ] Anxiety
- [ ] Depression
- [ ] Mood Swings
- [ ] Nervousness
- [ ] Poor Memory
- [ ] Tension
- [ ] Convulsions
- [ ] Dizziness
- [ ] Headaches
- [ ] Fainting
- [ ] Loss of Balance
- [ ] Fatigue
- [ ] Restlessness
- [ ] Insomnia
- [ ] Light Sensitivity
- [ ] Reduced Appetite
- [ ] Weakness
- [ ] Weight Gain
- [ ] Weight Loss
- [ ] Other: ________________________________
- [ ] No additional symptoms

**Are you restricted in any of the following areas as a result of this accident / injury?**
- [ ] Daily Living
- [ ] Work/Occupational
- [ ] Recreational Activities
- [ ] Other: ________________________________
- [ ] No restrictions

**Have you missed work due to this accident / injury?**
- [ ] Missed no work
- [ ] Limited work activity
- [ ] Missed work from: ___________ to ___________

**Did you self treat your symptoms?**
- [ ] Ice
- [ ] Heat
- [ ] Bed rest
- [ ] OTC Medication
- [ ] Other: ________________________________
- [ ] Did not self treat
Did you seek health care elsewhere?

- General Practitioner
- Internist
- Chiropractor
- Neurologist
- Orthopedist
- General Surgeon
- Plastic Surgeon
- Psychologist
- Other: ____________________________
- Did not seek other health care

Name/s of doctor/s: ____________________________

Diagnosis, treatment and recommendations: ____________________________

Have you had any of the following tests?

- CT Scan
- MRI
- EMG
- Other: ____________
- No tests

What is the reason for seeking today’s consultation?

- Persisting Complaints
- Worsening of Symptoms
- Other: ____________________________

Have you contacted an insurance adjuster or representative regarding this claim?

- No
- Yes—Company: ____________________________ Claim#: ____________

Adjuster: ____________________________ Phone: ____________________________

Have you engaged the services of an attorney?

- No
- Yes—Attorney: ____________________________

Address: ____________________________ Phone: ____________________________

Have you filed an accident / injury report?

- No
- Yes

Have you filed for insurance benefits?

- No
- Yes

Additional information: ____________________________

______________________________

I certify that the information provided above is accurate and complete to the best of my knowledge.

______________________________  
Patient Name (Please Print)  
Patient Signature

______________________________  
Date Signed  
Witness

For office use only:

Patient referred for MRI:  
- No  
- Yes—Name: ____________________________

Patient referred to a neurologist:  
- No  
- Yes—Name: ____________________________

Referring chiropractor: ____________________________