



— GET WELL —
CHIROPRACTIC

Case Number _____

Today's Date _____

CA _____ DC _____

1. Accident / Injury Questionnaire

Title: _____ First: _____ MI: _____ Last: _____

Date of accident: _____ Time of accident: _____: _____ am / pm

County in which accident took place: _____ State: _____

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):

- | | | | | |
|--|--|--|--|--|
| <input type="radio"/> <input type="checkbox"/> PAIN CUTS Head | <input type="radio"/> <input type="checkbox"/> PAIN CUTS Neck | <input type="radio"/> <input type="checkbox"/> PAIN CUTS Upper/Mid Back | <input type="radio"/> <input type="checkbox"/> PAIN CUTS Lower Back | <input type="radio"/> <input type="checkbox"/> PAIN CUTS Pelvis |
| <input type="radio"/> <input type="checkbox"/> Abdomen | <input type="radio"/> <input type="checkbox"/> Shoulders | <input type="radio"/> <input type="checkbox"/> Chest/Rib Cage | <input type="radio"/> <input type="checkbox"/> Arms | <input type="radio"/> <input type="checkbox"/> Elbows |
| <input type="radio"/> <input type="checkbox"/> Forearms | <input type="radio"/> <input type="checkbox"/> Wrists | <input type="radio"/> <input type="checkbox"/> Hands | <input type="radio"/> <input type="checkbox"/> Buttocks | <input type="radio"/> <input type="checkbox"/> Hips |
| <input type="radio"/> <input type="checkbox"/> Thighs | <input type="radio"/> <input type="checkbox"/> Knees | <input type="radio"/> <input type="checkbox"/> Legs | <input type="radio"/> <input type="checkbox"/> Ankles | <input type="radio"/> <input type="checkbox"/> Feet |
| <input type="radio"/> <input type="checkbox"/> Other: _____ | <input type="radio"/> <input type="checkbox"/> Other: _____ | | | |

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:

- | | | | | |
|---------------------------------------|------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Upper/Mid Back | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Shoulders | <input type="checkbox"/> Chest/Rib Cage | <input type="checkbox"/> Arms | <input type="checkbox"/> Elbows |
| <input type="checkbox"/> Forearms | <input type="checkbox"/> Wrists | <input type="checkbox"/> Hands | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Thighs | <input type="checkbox"/> Knees | <input type="checkbox"/> Legs | <input type="checkbox"/> Ankles | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> No x-rays taken |

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

- | | | | | |
|----------------------------------|---------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Upper/Mid Back | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Chest/Rib Cage |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> No CAT scan |

A MRI was performed on what body part/s:

- | | | | | |
|----------------------------------|---------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Upper/Mid Back | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Chest/Rib Cage |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> No MRI |

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

- | | |
|---|--|
| <input type="checkbox"/> Concussion: _____ | <input type="checkbox"/> Whiplash: _____ |
| <input type="checkbox"/> Disc Injury: _____ | |
| <input type="checkbox"/> Dislocation: _____ | |
| <input type="checkbox"/> Fracture: _____ | |
| <input type="checkbox"/> Sprain: _____ | |
| <input type="checkbox"/> Strain: _____ | |
| <input type="checkbox"/> Laceration: _____ | |
| <input type="checkbox"/> Contusions: _____ | |

Describe any additional diagnosis given: _____

What treatment was administered at the hospital?

- | | | | | | |
|--|---------------------------------------|---------------------------------|----------------------------------|--|------------------------------------|
| <input type="checkbox"/> Oral Medication | <input type="checkbox"/> Sutures | <input type="checkbox"/> Splint | <input type="checkbox"/> Collar | <input type="checkbox"/> Injection | <input type="checkbox"/> Ice Packs |
| <input type="checkbox"/> Cast | <input type="checkbox"/> Support | <input type="checkbox"/> Brace | <input type="checkbox"/> Surgery | <input type="checkbox"/> Hot Packs | <input type="checkbox"/> Bandages |
| <input type="checkbox"/> Antiseptics | <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> No Treatment | |

Upon discharge, whom were you told to see?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Internist | <input type="checkbox"/> General Surgeon | <input type="checkbox"/> Plastic Surgeon |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> No one | |

Upon discharge, what recommendations were made?

- | | | | | | |
|---------------------------------------|------------------------------|-------------------------------|---------------------------------|--|--|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Ice | <input type="checkbox"/> Heat | <input type="checkbox"/> Collar | <input type="checkbox"/> Support | <input type="checkbox"/> Time off work |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> No further care | <input type="checkbox"/> No recommendations |

Upon discharge, what medications were prescribed?

- | | | | |
|---------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> 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?

	Head	Jaw	Neck	Upper	Mid Back	Low Back	Pelvis	Chest/Ribs	Abdomen	Shoulders	Arms	Elbows	Forearms	Wrists	Hands/Fingers	Buttocks	Hips	Thighs	Knees	Legs	Ankles	Feet/Toes	
(Right)																							
(Left)																							
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: _____