INJURY QUESTIONNAIRE

NAME: _____ Date & Time of Injury _____

Where did accident happen?
Address: _____ City, State: _____

Telephone: _____ Insurance/Attorney: _____

Claim Adjuster: _____ Claim #_____

Describe the accident in your own words:

Was anyone else present or witnessed your injury □ Yes □ No; whom _____
Did you report your injury/accident to anyone: □ Yes □ No; whom _____

Immediately following the accident, how did you feel? □ dizzy/dazed □ disoriented □ unconscious
□ nervous □ nauseous □ upset □ weak □ Other _____

Did you go to hospital □ Yes □ No Were you admitted to the hospital? □ Yes □ No if yes how long? _____
If you went to hospital, when? □ At time of accident □ Next day
How did you get to hospital? □ Ambulance □ Police Car □ Private Transportation
Name of Hospital:_____
Attended by Dr. _____
… what treatment was given?
☐none ☐placed in a cervical collar ☐x-rayed ☐ given stitches ☐Bandaged
☐ given pain medication ☐given instructions regarding concussions
☐given instructions regarding sprains and strains ☐ Physical Therapy
☐instructed to call a Orthopedic Surgeon ☐instructed to call a private physician
☐referred to this office for treatment ☐ Other _____
_____

Have you seen any other doctor as a result of this accident? □ Yes □ No
Doctor's name

CHIEF Complaints or Symptoms: **Name:** **Date:**

☐**Neck pain** check off the areas that the pain runs into from the neck ☐headache ☐Migraine Headache ☐upper back pain	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand ☐right shoulder ☐right arm ☐right forearm ☐right hand

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides

☐Dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability
☐fear of driving in a car ☐a loss of concentration ☐jaw clenching ☐grinding of teeth at night ☐ nightmares ☐difficulty with sleeping at night

☐**Low Back Pain** select the areas of radiation, if any...	☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? □Yes □No
If yes please give dates: _____
Type of employment: _____
Have you had previous injuries or accidents? □Yes □ No
Description of previous Accident: _____
Description of previous injuries: _____
Is there any residual pain from the previous injury? □Yes □No
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____