



Case Number

Today's Date

### 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: \_\_\_\_\_  
\_\_\_\_\_

*PAIN CUTS* *PAIN CUTS* *PAIN CUTS* *PAIN CUTS* *PAIN CUTS*

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):

○ □ Head ○ □ Neck ○ □ Upper/Mid Back

- |                       |                          |          |                       |                          |              |                       |                          |                |
|-----------------------|--------------------------|----------|-----------------------|--------------------------|--------------|-----------------------|--------------------------|----------------|
| <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"/> | Hands          |
| <input type="radio"/> | <input type="checkbox"/> | Forearms | <input type="radio"/> | <input type="checkbox"/> | Wrists       | <input type="radio"/> | <input type="checkbox"/> | Legs           |
| <input type="radio"/> | <input type="checkbox"/> | Buttocks | <input type="radio"/> | <input type="checkbox"/> | Hips         | <input type="radio"/> | <input type="checkbox"/> | Other: _____   |
| <input type="radio"/> | <input type="checkbox"/> | Thighs   | <input type="radio"/> | <input type="checkbox"/> | Knees        | <input type="radio"/> | <input type="checkbox"/> | Feet           |
| <input type="radio"/> | <input type="checkbox"/> | Ankles   | <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: \_\_\_\_\_

When did you go to the hospital?

- Next Day       Immediately       Later That 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"/> | Chest/Rib Cage |
| <input type="checkbox"/> | Abdomen      | <input type="checkbox"/> | Shoulders | <input type="checkbox"/> | Hands          |
| <input type="checkbox"/> | Arms         | <input type="checkbox"/> | Elbows    | <input type="checkbox"/> | Legs           |
| <input type="checkbox"/> | Forearms     | <input type="checkbox"/> | Wrists    | <input type="checkbox"/> | Feet           |
| <input type="checkbox"/> | Buttocks     | <input type="checkbox"/> | Hips      |                          |                |
| <input type="checkbox"/> | Thighs       | <input type="checkbox"/> | Knees     |                          |                |
| <input type="checkbox"/> | Ankles       | <input type="checkbox"/> | Feet      |                          |                |
| <input type="checkbox"/> | Other: _____ |                          |           |                          |                |

**No x-rays taken**

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

- Head       Neck       Upper/Mid Back

Abdomen  Other: \_\_\_\_\_

**No CAT scan**

A MRI was performed on what body part/s:

Head  Neck  Upper/Mid Back  
 Lower Back  Chest/Rib Cage

Abdomen

<input type="checkbox"/>	Head	Jaw	Neck	Upper	Mid Back	Low Back	Pelvis	Chest/Ribs	Abdomen	Shoulders	Arms	Elbows	Forearms	Wrists	Hands/Fingers	Buttcks	Hips	Thighs	Knees	Legs	Ankles	Feet/Toes
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(Right)																							
(Left)																							
Pain																							
Burning																							
Numbness																							
Soreness																							
Stiffness																							
Swelling																							
Tingling																							
Weakness																							

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**

How much later did additional symptoms develop?

- Immediately     Hours     That Evening     Next Morning  
 Days     Week     Month     Other: \_\_\_\_\_  
 **No other symptoms**

**toms**

What additional symptoms developed?

Since your accident/injury, have you suffered from:

- Blurred Vision     Double Vision     Vision Trouble  
 Hearing Trouble