INJURY QUESTIONNAIRE

PATIENT NAME: ______________________________

HISTORY OF NON-AUTO INJURY?
If your injury was not caused by an automobile accident, skip to page 2 and make sure you fill page 4.

I. EXPLANATION OF ACCIDENT (Please check the appropriate answers)

1. DATE OF ACCIDENT: ____________________ TIME OF DAY: ________________
2. YOUR VEHICLE MAKE AND MODEL: ____ YEAR: _________________
3. YOUR SEAT: ☐ Driver ☐ Passenger (If Passenger) ☐ In the front ☐ Back ☐ Middle ☐ Other: ______________
4. OTHER VEHICLE MAKE AND MODEL: _______________________________________ YEAR: _________________
5. HOW WAS YOUR VEHICLE STRUCK? IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:

____

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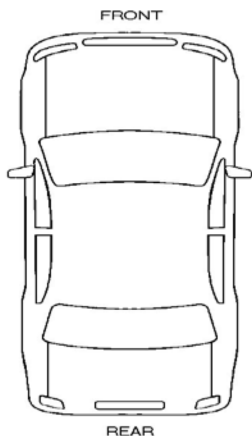
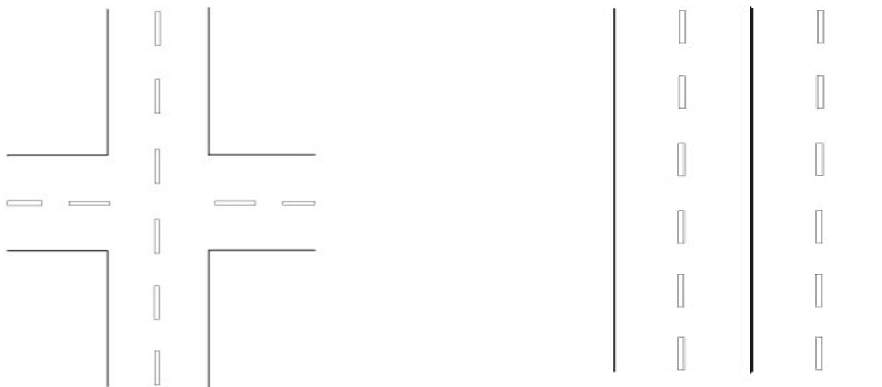
DRAW THE DAMAGE TO YOUR VEHICLE AND A DEPICTION OF THE ACCIDENT
If filling online: 1. Print form after filling fields 2. Finish drawing 3. Sign form





6. DAMAGE TO YOUR VEHICLE: ☐ Slight ☐ Moderate ☐Severe Estimate: $_____________ ☐ Pictures Attached
7. DAMAGE TO OTHER VEHICLE: ☐ Slight ☐ Moderate ☐Severe
8. WAS YOUR CAR STOPPED AT THE MOMENT OF IMPACT? ☐ No ☐ Yes If Yes WHY? ________________________
9. ROAD CONDITIONS: ☐ Dry and clear ☐ Damp ☐ Wet and rainy ☐ Other ______________________________
10. AT IMPACT WERE YOU: ☐ Unprepared ☐ Holding steering wheel ☐ Braced for impact
    ☐ Stepping hard on brake Looking ☐ R ☐ L ☐ Straight ahead
11. IF TURNED, WERE YOU TURNED AT THE: ☐ Waist ☐ Neck ☐ Both
12. WEARING SEATBELT? ☐ Yes ☐ No
13. USING HEADREST? ☐ Yes ☐ No (steering wheel. Dash, side window…)
14. DID ANY PART OF YOUR BODY STRIKE ANYTHING? ☐ No ☐ Yes What? ________________________________
15. DID YOU LOSE CONSCIOUSNESS? ☐ No ☐ Yes How long? ____
16. HOW DID YOU FEEL IMMEDIATELY AFTER THE INJURY?
    ☐ Shocked ☐ Shaky ☐ Nervous ☐ Scared ☐ Dazed ☐ Confused ☐ Dizzy ☐ Nauseated ☐ Other ___________
17. WERE THE POLICE NOTIFIED? ☐ Yes ☐ No Why not? ____
18. DO YOU HAVE A COPY OF THE POLICE REPORT? ☐ Yes ☐ No

II. EXPLANATION OF YOUR CONDITION

1. DID YOU FEEL PAIN IMMEDIATELY? ☐ Yes ☐ No
   IF YES, WHERE?
   ☐ Head ☐ Neck ☐ Forehead ☐ Upper Back ☐ Middle Back ☐ Lower Back
   ☐ Chest ☐ Rib Cage ☐ Side
   ☐ Eye ☐ Ear ☐ Cheek ☐ Nose ☐ Chin ☐ Mouth/Jaw
   ☐ Shoulder ☐ Arm ☐ Forearm ☐ Elbow ☐ Wrist ☐ Hand/Finger
   ☐ Abdomen ☐ Pelvis
   ☐ Hip ☐ Buttocks ☐ Thigh ☐ Lower Leg ☐ Knee ☐ Knee ☐ Ankle ☐ Foot/Toe

2. HOW LONG AFTER THE INJURY DID IT TAKE TO DEVELOPE PAIN?
   ☐ A few minutes later ☐ An hour Later ☐ A few hours later ☐ That evening ☐ The next morning
   ☐ A couple of days later ☐ A week later ☐ A couple of weeks later ☐ Other: ________________________________
3. DID YOU GO TO THE HOSPITAL? ☐ No ☐ Yes WHICH ONE? ____
   a. IF YES, HOW DID YOU GET THERE? ☐ Ambulance ☐ Drove self ☐ Ride from someone else
   b. WERE X-RAYS, CTs OR MRIs TAKEN? ☐ Yes ☐ No Explain ________________________________
   c. WERE YOU PRESCRIBED MEDICATION? ☐ Yes ☐ No Explain ________________________________
   d. WERE YOU ADMITTED (STAY)? ☐ No ☐ Yes How long? __________________________
4. HAVE YOU BEEN SEEN BY A DOCTOR OUTSIDE A HOSPITAL SINCE THE INJURY? ☐ No ☐ Yes
   IF YES LIST DOCTORS SEEN: ____
   ____
   a. WERE X-RAYS, CTs OR MRIs TAKEN? ☐ No ☐ Yes Explain ________________________
   b. WERE YOU PRESCRIBED MEDICATION? ☐ No ☐ Yes Explain ________________________
5. ARE YOU TAKING OVER THE COUNTER MEDICATION? ☐ No ☐ Yes Explain _______________________
6. DID YOU HAVE ANY PAIN FROM 6 MONTHS PREVIOUS--TO THE INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
7. HAVE YOU EVER HAD ANY SIMILAR SYMPTOMS BEFORE THIS INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
8. HAVE YOU HAD ANY OTHER UNRELATED INJURIES SINCE THE DATE OF THIS INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____

III. CHANGES IN LIFESTYLE DUE TO THIS INJURY

5. HAVE YOU MISSED ANY WORK AS A RESULT OF THIS INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
2. ARE THERE ANY JOB DUTIES YOU CAN'T PERFORM AS A RESULT OF THIS INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
3. WERE YOU? ☐ At work ☐ Going to work ☐ Leaving work
   IF ANY, EXPLAIN: ____
4. ARE THERE ANY HOME DUTIES OR SPORTS/RECREATION ACTIVITIES YOU CAN'T DO AS A RESULT OF THIS INJURY?
   ☐ No ☐ Yes IF YES, EXPLAIN: ____
5. ARE YOU LOSING SLEEP DUE TO YOUR PRESENT CONDITION? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
6. HAS YOUR SEXUAL ACTIVITY BEEN AFFECTED DUE TO YOUR PRESENT CONDITION? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____

IV. PLEASE LIST ALL OF YOUR *CURRENT SYMPTOMS*

HEAD
- [ ] Blurred Vision
- [ ] Double Vision
- [ ] Eyes Sensitive to Light
- [ ] Eye Pain
- [ ] Eye Strain
- [ ] Pain Behind the Eyes
- [ ] Hearing Problems
- [ ] Buzzing/Ringing in ears
- [ ] Loss/Change in Smell
- [ ] Loss/Change in Taste
- [ ] Dizziness
- [ ] Equilibrium Problems
- [ ] Face Flushed
- [ ] Pain at Base of Skull
- [ ] Headaches
- [ ] Head Feels Heavy

JAW/TEETH
- [ ] Teeth Missing
- [ ] Loose Teeth
- [ ] Tooth Ache
- [ ] Pain with Chewing
- [ ] Clicking with Chewing
- [ ] Jaw Pain
- [ ] Jaw Locking

NECK
- [ ] Neck Pain
- [ ] Neck Spasm
- [ ] Neck Stiffness
- [ ] Neck Swelling
- [ ] Pinched Nerve in Neck
- [ ] Grinding Sound in Neck

SHOULDER
- [ ] Shoulder pain
- [ ] Shoulder Spasm
- [ ] Shoulder Stiffness
- [ ] Shoulder Swelling
- [ ] Can’t Raise Arms Over Head
- [ ] Pain in Shoulder Joint
- [ ] Pinched Nerve in Shoulder

CHEST
- [ ] Chest Pain
- [ ] Chest Tightness
- [ ] Difficulty Breathing
- [ ] Rapid Heart Beat
- [ ] Palpitation

ARMS/HANDS
- [ ] Pain in Upper Arm
- [ ] Pain in Lower Arm
- [ ] Numbness/Tingling in Arms/Hands
- [ ] Cold Arm/Hand
- [ ] Elbow Pain
- [ ] Elbow Stiffness
- [ ] Elbow Swelling
- [ ] Wrist Pain
- [ ] Wrist Stiffness
- [ ] Wrist Swelling
- [ ] Hand Pain
- [ ] Hand Stiffness
- [ ] Hand Swelling
- [ ] Weakness in Arms
- [ ] Loss of Grip Strength

MIDDLE BACK
- [ ] Mid Back Pain
- [ ] Mid Back Spasm
- [ ] Mid Back Stiffness
- [ ] Mid Back Swelling
- [ ] Pain Between Shoulder Blades

ABDOMEN
- [ ] Pain Across Pelvis
- [ ] Constipation
- [ ] Gas
- [ ] Nausea
- [ ] Stomach Pain

LOW BACK
- [ ] Low Back Pain
- [ ] Low Back Spasm
- [ ] Low Back Stiffness
- [ ] Low Back Swelling
- [ ] Pinched Nerve in Back
- [ ] Flank Pain (under ribs)
- [ ] Tailbone Pain
- [ ] Sacro-Iliac Pain

HIPS
- [ ] Hip pain
- [ ] Hip Spasm
- [ ] Hip Stiffness
- [ ] Hip Swelling
- [ ] Can’t Put Weight on Hip
- [ ] Pain in Hip Joint

LEGS/FEET
- [ ] Pain in Thigh
- [ ] Pain in Lower Leg
- [ ] Numbness/Tingling in Leg/Foot
- [ ] Cold Leg/Foot
- [ ] Knee Pain
- [ ] Knee Stiffness
- [ ] Knee Swelling
- [ ] Ankle Pain
- [ ] Ankle Stiffness
- [ ] Ankle Swelling
- [ ] Foot Pain
- [ ] Foot Stiffness
- [ ] Foot Swelling
- [ ] Weakness in Legs
- [ ] Difficulty Standing/Walking

NERVOUS SYSTEM
- [ ] Anxiety
- [ ] Irritability/Angry
- [ ] Nervous/Tense
- [ ] Stressed
- [ ] Depressed
- [ ] Mental Dullness
- [ ] Memory Loss
- [ ] Forgetful
- [ ] Inability to Concentrate
- [ ] Tremors/Shaky
- [ ] Insomnia

OTHER
- [ ] Loss of Appetite
- [ ] Excessive Thirst
- [ ] Excessive Hunger
- [ ] Extreme Fatigue
- [ ] Abnormal Urination
- [ ] Abnormal Bowel Changes
- [ ] Vomiting
- [ ] Runny Nose
- [ ] Nose Bleeds
- [ ] Blood in Urine or Stools
- [ ] Tender Breasts
- [ ] Change in Menses
- [ ] Change in Libido
- [ ] Impotence
- [ ] Hemorrhoids
- [ ] Swollen Glands
- [ ] Contusions
- [ ] Abrasions
- [ ] Lacerations

OTHER:

V. HISTORY OF NON-AUTO RELATED INJURY

(skip and sign and date below if auto accident)

1. DATE OF INJURY: ______________________ TIME OF DAY: __________________

2. LOCATION OF INJURY: ____

3. WITNESSES? ☐ No ☐ Yes

4. IN YOUR OWN WORDS, PLEASE DESCRIBE THE INJURY:

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PATIENT SIGNATURE ____________________________ DATE ____________________________