ATLANTA INNOVATIVE MEDICINE
8460 Holcomb Bridge Road
2nd Floor, Alpharetta, GA 30022

Accident/Injury Questionnaire

Patient Name _____ Date _____

Nature of the Accident

1. Date of accident: _____ Time of day: _____am / pm

2. Was this a(n): ❒ Automobile Accident ❒ Workmen's Compensation Accident/Injury
❒ Slip/Fall Accident ❒ Other: _____

3. Please describe the accident in your own words: _____
_____
_____
_____

4. Did you have any physical complaints BEFORE THE ACCIDENT? ❒ Yes ❒ No
If yes, describe: _____
_____
_____

5. Please describe how you felt:
a. DURING the accident: _____
_____

b. IMMEDIATELY AFTER the accident: _____
_____

c. LATER THAT day: _____
_____

d. The NEXT day: _____
_____

6. What are your PRESENT complaints and symptoms? _____
_____
_____

7. Did you receive emergency care at the scene of the accident? ❒ Yes ❒ No
If yes, describe (e.g., neck brace, back board, etc.) : _____
_____

8. Were you taken to the hospital after the accident? ❒ Yes ❒ No
If yes, please list hospital name, treatment received, and how you were transported to hospital (e.g., friend, ambulance, self, etc.):
_____
_____

9. Were x-rays or CT/MRI scans taken? ❒ Yes ❒ No
If so, what test was performed and on what body part(s) (e.g., neck, upper back, etc.)? _____
_____

10. Were you given a diagnosis at the hospital? ❒ Yes ❒ No
If yes, describe in detail: _____
_____

11. Have you received any treatment by another doctor since the accident or are you currently under care for your injuries? ❒ Yes ❒ No
If yes, please list doctor name and address: _____
_____

12. What type of treatment did you receive (e.g., prescriptions, other medications, etc.): _____
_____

13. Since this injury occurred, are your symptoms:
❒ Improving ❒ Getting worse ❒ Remaining the same

14. Check the symptoms you've noticed since the accident:

❒ Headache	❒ Irritability	❒ Loss of Balance	❒ Loss of Smell	❒ Pins & Needles (Legs)
❒ Chest Pain	❒ Numbness in Toes	❒ Fatigue	❒ Fever	❒ Ringing in Ears
❒ Back Pain	❒ Face Flushed	❒ Stomach Upset	❒ Anxiety	❒ Dizziness
❒ Stiff Back	❒ Hands Cold	❒ Sleeping Problems	❒ Pins & Needle (Arms)	❒ Tension
❒ Neck Pain	❒ Feet Cold	❒ Depression		❒ Memory Loss
❒ Stiff Neck	❒ Shortness of Breath	❒ Fainting		

Other: _____

15. Have you missed work due to this accident/injury? ❒ Yes ❒ No
If yes, please complete this question:
a) Last day worked: _____
b) Amount of time missed: _____
c) Type of employment: _____

Insurance/Attorney Information

16. Have you contacted an insurance adjuster or representative regarding this injury? ❒ Yes ❒ No
If yes, please list: Company name: _____ Phone: _____
Adjuster Name: _____ Claim #: _____

17. Have you engaged services of an attorney? ❒ Yes ❒ No
If yes, Attorney name: _____ Phone: _____
Address: _____

18. Do you have private health insurance? ❒ Yes ❒ No
If yes, Insurance company name: _____ Phone: _____
Subscriber Name: _____
ID/Group Number: _____

19. Is there any additional information about this accident that you'd like to share with us?
_____
_____
_____
_____

Restrictions in Activities of Daily Living

In this section please check **YES** if you are Experiencing Difficulty/Pain or
Unable to Perform these Activities of Daily Living in the corresponding column.

Health Care	**Difficult/Painful**	**Unable to Perform**
Bathing	O	O
Getting into/out of bathtub	O	O
Getting on/off toilet	O	O
Washing/grooming hair	O	O
Taking shoes on/off	O	O
Applying lotion	O	O
Brushing teeth	O	O

Activities Involving Posture	**Difficult/Painful**	**Unable to Perform**
Prolonged standing	O	O
Prolonged sitting	O	O
Prolonged walking	O	O
Climbing stairs	O	O
Bending	O	O
Lying on stomach	O	O
Lying on back	O	O
Kneeling/squatting	O	O

Travel/Driving	**Difficult/Painful**	**Unable to Perform**
Turning head while reversing	O	O
Rotating body while reversing	O	O
Prolonged sitting as driver/passenger	O	O
Driving on bumpy road	O	O

Social & Recreational Activities	**Difficult/Painful**	**Unable to Perform**
Dancing	O	O
Playing sports	O	O
Participating in aerobic activities	O	O
Weight lifting/body building	O	O
Running/jogging	O	O

Household Responsibilities	**Difficult/Painful**	**Unable to Perform**
Scrubbing tub/floors	O	O
Vacuuming/mopping	O	O
Taking out trash	O	O
Washing dishes	O	O
Doing laundry	O	O
Caring for children	O	O

Sexual Functions	**Difficult/Painful**	**Unable to Perform**
Participation in sexual activities	O	O

Sleeping Habits	**Yes**	**No**
Do you have trouble falling asleep?	O	O
Is your sleep interrupted due to pain?	O	O
Are you awakened early due to pain?	O	O
Do you have trouble sleeping without medication?	O	O