Accident/Injury Questionnaire

8460 Holcomb Bridge Road
2nd Floor, Alpharetta, GA 30022

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

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