

Accident/ Injury Questionnaire

Total Healthcare
6690 Roswell Rd Suite 510
Sandy Springs, Ga 30318
(678)999.8531

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.

<u>Health Care</u>	Difficult/Painful	Unable to Perform
Bathing	<input type="radio"/>	<input type="radio"/>
Getting into/out of bathtub	<input type="radio"/>	<input type="radio"/>
Getting on/off toilet	<input type="radio"/>	<input type="radio"/>
Washing/Grooming hair	<input type="radio"/>	<input type="radio"/>
Taking shoes on/off	<input type="radio"/>	<input type="radio"/>
Applying lotion	<input type="radio"/>	<input type="radio"/>
Brushing Teeth	<input type="radio"/>	<input type="radio"/>
<u>Activities Involving Posture</u>	Difficult/Painful	Unable to Perform
Prolonged standing	<input type="radio"/>	<input type="radio"/>
Prolonged sitting	<input type="radio"/>	<input type="radio"/>
Prolonged walking	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>
Bending	<input type="radio"/>	<input type="radio"/>
Laying on stomach	<input type="radio"/>	<input type="radio"/>
Laying on back	<input type="radio"/>	<input type="radio"/>
Kneeling/Squatting	<input type="radio"/>	<input type="radio"/>
<u>Travel/Driving</u>	Difficult/Painful	Unable to Perform
Turning head while reversing	<input type="radio"/>	<input type="radio"/>
Rotating body while reversing	<input type="radio"/>	<input type="radio"/>
Prolonged sitting as driver/passenger	<input type="radio"/>	<input type="radio"/>
Driving on bumpy road	<input type="radio"/>	<input type="radio"/>
<u>Social & Recreational Activities</u>	Difficult/Painful	Unable to Perform
Dancing	<input type="radio"/>	<input type="radio"/>
Playing sports	<input type="radio"/>	<input type="radio"/>
Participating in aerobic activities	<input type="radio"/>	<input type="radio"/>
Weight lifting/body building	<input type="radio"/>	<input type="radio"/>
Running/jogging	<input type="radio"/>	<input type="radio"/>
<u>Household Responsibilities</u>	Difficult/Painful	Unable to Perform
Scrubbing tub/floors	<input type="radio"/>	<input type="radio"/>
Vacuuming/mopping	<input type="radio"/>	<input type="radio"/>
Taking out trash	<input type="radio"/>	<input type="radio"/>
Washing dishes	<input type="radio"/>	<input type="radio"/>
Doing laundry	<input type="radio"/>	<input type="radio"/>
Caring for children	<input type="radio"/>	<input type="radio"/>
<u>Sexual Functions</u>	Difficult/Painful	Unable to Perform
Participation in sexual activities	<input type="radio"/>	<input type="radio"/>
<u>Sleeping Habits</u>	Yes	No
Do you have trouble falling asleep?	<input type="radio"/>	<input type="radio"/>
Is your sleep interrupted due to pain?	<input type="radio"/>	<input type="radio"/>
Are you awakened early due to pain?	<input type="radio"/>	<input type="radio"/>
Do you have trouble sleeping without medication?	<input type="radio"/>	<input type="radio"/>