

Patient Questionnaire – Other-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient Yes No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Additional Information Related to the Condition:

Describe your pain: Burning Sharp Dull Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No

When? ___/___/___

Describe: _____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

- | | | | | | |
|---|--|--|---------------------------------------|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Nausea | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in legs/feet | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever | <input type="checkbox"/> Fatigue |

- Irritability
- Loss of Smell
- Chest pain/rib pain
- Pain in arms/hands
- Pain in legs/feet
- Jaw pain
- Loss of strength - arms
- Burning muscle pain
- Loss of strength - legs
- Difficulty swallowing
- Sharp/shooting pain

Other _____

Have you experienced changes to:

- Eyes (sight)
- Ears (hearing)
- Nose (smell)
- Mouth (taste)
- Bladder
- Bowels
- Sleep
- Emotion
- Appetite

Please Explain: _____

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Notes: _____

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

- 1) _____ / /
- 2) _____ / /
- 3) _____ / /

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

- Heart Disease
- Diabetes
- Cancer
- Stroke
- High Blood Pressure
- Thyroid Problems
- Tuberculosis
- Prostate Disorder
- Kidney Problems
- Asthma
- Ulcer
- Seizure Disorder

Other: _____