Patient Questionnaire – Work-Related-Auto-Accident

LE RÊVE SPINAL CARE
Physiotherapy - Chiropractic - Rehabilitation - Pain Management

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: _____

_____

_____

_____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage Amount Estimate: $_____ : ☐ Minor ☐ Major ☐ Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender
☐ Minor ☐ Major ☐ Totaled

Where did the accident happen? Street Names: _____ City/State _____

Was it? ☐ Controlled Intersection ☐ Uncontrolled ☐ Not Intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Weather Conditions: ☐ Sunny ☐ Rainy ☐ Cloudy

Street Surface: ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other _____

Type of Impact: ☐ Rear end ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on Impact: ☐ Locked Tight ☐ Loosely Applied ☐ Foot not on brake

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? ☐ Yes ☐ No

Shoulder harness: ☐ Yes ☐ No Headrest: ☐ Yes ☐ No Headrest Position: ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No Did they deploy? ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other _____

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part: _____

What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of Consciousness? ☐ Yes ☐ No For how long? _____

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: _____ How long there? _____

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other X-rays _____

Medication Given? ☐ Yes ☐ No RX: _____

Other instruction: _____ Follow-up: _____

Work-Accident Specific Information:

Check all that apply:

☐ Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?

☐ Did the accident occur during your normal working hours?

☐ Did you report the accident to your Employer?

☐ Is your Employer covered by Workers' Compensation Insurance under state law?

☐ Has your Employer prepared an initial written report?

☐ Does the Employer's Report describe the condition or symptoms you are experiencing?

☐ Has a claim number been issued for this accident?

☐ Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?

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:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain

☐ Numbness in arms/hands ☐ Buzzing in Ears ☐ Constipation ☐ Nervousness ☐ Numbness in legs/feet ☐ Loss of Balance
☐ Cold Sweats ☐ Tension ☐ Shortness of Breath ☐ Fainting ☐ Fever ☐ 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: _____