406 E. South Blvd., Crawfordsville, IN 47933 | (765) 362 1111 | www.russellfamilychiro.com

PATIENT QUESTIONNAIRE – WORK-RELATED AUTO ACCIDENT

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

Date of Exam: ___/___/___ 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: ____

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Describe the condition or symptoms caused by the Accident: ____

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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: ____

____

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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: ____

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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: ____