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

PATIENT QUESTIONNAIRE – OTHER 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: ____
____
____
____

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:

☐ 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: ____