

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: Sharp Dull Stabbing Aching Radiating Burning Throbbing Numbness

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 |
|-------|-------------------|--------------------|
| _____ | _____ | ___/___/___ |
| _____ | _____ | ___/___/___ |

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): _____

List all medications you are now taking and why: _____