AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date________________________

Patient ____ No.________________________
Sex________ Marital Status________ Date of Birth________ Home Phone________________________
Address____________________________City________________ State Zip______________
Email:__________________________Occupation______________________________
Who referred you to our office?____
Social Sec. #________________ Business Phone______________ Company Name______________
Company Address____
Please explain in detail how your accident happened?____

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Driver of other vehicle (if any)______________________________ Date of Birth______________
Insurance Company______________ Address________________Phone No:______________
Policy No.____
Claim No.____
Name of person who has made contact with you____
Name of driver of vehicle in which you were injured (self or other)______________________________
Insurance Company______________Address________________ Phone No:______________
Policy No.____
Claim No.____
Name of Person who has made contact with you____
Have you retained an attorney? ☐ Yes ☐ No ☐ Not Yet
If so, his/her name, address & phone #____
Give time and date present injury occurred__________________ ☐ AM ☐ PM ____/____/____
You were heading? ☐ North ☐ South ☐ East ☐ West on______________(street or highway)
Number of people in your vehicle______________
Were police notified? ☐ Yes ☐ No Did head strike windshield or object? ☐ Yes ☐ No
Were you knocked unconscious ☐ Yes ☐ No If so, for how long______________________
You were struck from? ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
You were? ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices
Did you feel pain immediately after the accident? ☐ Yes ☐ No ☐ Later that day ☐ Next day ☐ When________
Where did you feel pain immediately after the accident?________________________________
Where were you taken after the accident?____
Was treatment given?____
Was any doctor consulted after the accident? ☐ Yes ☐ No
If so, give doctor's name______________________________☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.
Doctor's Diagnosis____
What treatment was given?____
How often did you see the doctor?____
How long did you see the doctor?____
Have you ever had any complaints in the involved area before? ☐ Yes ☐ No
If so, what were the complaints?____
Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No
Since the injury, are your symptoms ☐ Improving? ☐ Getting worse? ☐ The same?

@PM, Inc., 1996

HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Date:______________________________

Patient:____ **No.:**______________________________

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ YES ☐ NO

SYMPTOM LOCALIZATION

P ___ Pain
N ___ Numb
S ___ Spasm
T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ ____________________

CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw Pain

Patient's Signature ______________________________

●●●●●●●●●●●●●●●●●●●●●●DO NOT WRITE BELOW THIS LINE●●●●●●●●●●●●●●●●●●●●●●●

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Patient Accepted? ☐ **Yes** ☐ **No** **Doctor's Signature**______________________________