PATIENT QUESTIONNAIRE

Name: ______________________ Accident Date: ______________________

Birth Date: ______________________ ______________________

Gender: ______________________ Dominant Hand: ☐ Right ☐ Left ☐ Both

ACCIDENT DETAILS

1.	Type of accident	☐ MVA Other: ______
2.	Please describe the accident	______
3.	Were you the	☐ Driver ☐ Front Passenger ☐ Back Passenger ☐ Not Applicable ☐ Bicycle rider ☐ Pedestrian ☐ Other ______
4.	What was your vehicle?	☐ Automobile ☐ Pickup Truck ☐ SUV ☐ Other: ______ ☐ Motorcycle ☐ Bicycle
5.	What was other vehicle?	☐ Automobile ☐ Pickup Truck ☐ SUV ☐ Other: ______ ☐ Motorcycle ☐ Bicycle
6.	Where was your vehicle hit?	☐ Front end ☐ Rear end ☐ Right front ☐ Right rear ☐ Left front ☐ Left rear ☐ Right side ☐ Left side Other: ______
7.	Were you seatbelted?	☐ Yes ☐ No ☐ Not Applicable
8.	Were you helmeted?	☐ Yes ☐ No ☐ Not Applicable
9.	Did the Airbag deploy?	☐ Yes ☐ No ☐ Don't Recall
10.	Were you injured by airbag?	☐ Yes ☐ No If yes, describe: ______
11.	Braced at time of impact?	☐ Yes ☐ No ☐ Don't Recall
12.	Did you hit your head?	☐ Yes ☐ No ☐ Don't Recall If yes, where? ______
13.	Did you lose consciousness?	☐ Yes ☐ No ☐ Don't Recall
14.	Did you recall the impact?	☐ Yes ☐ No ☐ Don't Partially ______
15.	Were you dazed or stunned?	☐ Yes ☐ No ☐ Don't Recall Describe: ______
16.	Did you have these symptoms?	☐ Dizziness ☐ Nausea ☐ Vomiting ☐ Vision changes ☐ Trouble speaking ☐ Confusion
17.	Were you in immediate pain?	☐ Yes ☐ No ☐ Don't Recall Where: ______ If not, when did you notice pain? ______
18.	Describe your injuries:	______
19.	Did you have any cuts?	☐ Yes ☐ No If yes, describe: ______
20.	Did you notice ringing in your ears immediately?	☐ Yes ☐ No If yes, describe: ______
21.	Were you deafened by the sound of the impact?	☐ Yes ☐ No If yes, describe: ______

HOSPITAL / ER

1.	Did you go to the ER?	☐ Yes ☐ No Which hospital? ______
2.	How were you transported?	☐ Ambulance ☐ Drove self ☐ Spouse ☐ Family member ☐ Friend ☐ Airlift Other: ______
3.	How soon after the accident did you go to the hospital?	______
4.	Were you admitted to the hospital overnight?	☐ Yes ☐ No For how long? ______

HOSPITAL / ER (CONTINUED)

5.	Were X-rays performed?	☐ Yes ☐ No	Details	___
6.	Were CT's performed?	☐ Yes ☐ No	Details:	___
7.	Were MRI's performed?	☐ Yes ☐ No	Details:	___
8.	What treatments/discharge instructions did you receive?	☐Medication ☐Surgery ☐ Stitches ☐ Bandaging ☐Arm sling	☐ Cane ☐ Crutches ☐ Cast ☐ Cervical collar ☐ Back brace	☐ Told to apply heat ☐ Told to apply ice ☐ Told to rest Other: ___

OTHER TREATING DOCTORS AFTER THE ER

1.	Doctor's Name/Specialty:	___			
	Diagnostic Testing:	☐**MRI**	☐**CT**	☐**X-rays**	☐**Other**
	Treatments Received:	☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ Other ___	☐ Ultrasound ☐ Electrical Stim ☐ Medications	☐ Injections ☐ Therapy	
	Benefit from treatment:	☐ Partial	☐ Complete	☐ None	
2.	Doctor's Name/Specialty:	___			
	Diagnostic Testing:	☐**MRI**	☐**CT**	☐**X-rays**	☐**Other**
	Treatments Received:	☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ Other ___	☐ Ultrasound ☐ Electrical Stim ☐ Medications	☐ Injections ☐ Therapy	
		☐ Partial	☐ Complete	☐ None	
3.	Doctor's Name/Specialty:	___			
	Diagnostic Testing:	☐**MRI**	☐**CT**	☐**X-rays**	☐**Other**
	Treatments Received:	☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ Other ___	☐ Ultrasound ☐ Electrical Stim ☐ Medications	☐ Injections ☐ Therapy	
	Benefit from treatment:	☐ Partial	☐ Complete	☐ None	
4.	Doctor's Name/Specialty:	___			
	Diagnostic Testing:	☐**MRI**	☐**CT**	☐**X-rays**	☐**Other**
	Treatments Received:	☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ Other ___	☐ Ultrasound ☐ Electrical Stim ☐ Medications	☐ Injections ☐ Therapy	
	Benefit from treatment:	☐ Partial	☐ Complete	☐ None	

CURRENT STATUS OF SYMPTOMS

Since the accident symptoms are:	☐Completely Recovered	☐A Lot Better ☐A Little Better	☐Worse ☐Unchanged

CURRENT SYMPTOMS

NERVOUSNESS

1.	Are you nervous about driving?	☐Yes	☐No	☐Constantly	☐Occasionally	How often?_____
2.	Do you have nightmares?	☐Yes	☐No	☐Constantly	☐Occasionally	How often?_____
3.	Do you have flashbacks?	☐Yes	☐No	☐Constantly	☐Occasionally	How often?_____
4.	Do you have intrusive thoughts?	☐Yes	☐No	☐Constantly	☐Occasionally	How often?_____
5.	Do you have avoidance behavior?	☐Yes	☐No	☐Constantly	☐Occasionally	How often?_____
6.	Are you easily startled?	☐Yes	☐No	☐Constantly	☐Occasionally	How often?______
7.	Do you have panic attacks?	☐Yes	☐No	☐Constantly	☐Occasionally	How often?______
8.	Do you have suicidal thoughts?	☐Yes	☐No	☐Constantly	☐Occasionally	How often?______

HEADACHES

1.	Have you experienced headaches since the accident?	☐Yes ☐No ☐Constantly ☐Occasionally How often?_________
2.	How severe are they?	☐Mild ☐Moderate ☐Severe ☐Mild-Moderate ☐Moderate -Severe ☐Incapacitating
3.	How bad is the pain? (Level 10 being the highest)	☐1/10☐2/10☐3/10☐4/10 ☐ 5/10 ☐6/10☐7/10 ☐8/10 ☐9/10 ☐ 10/10 Range ___/10
4.	Where is the pain located?	☐Front of head ☐Behind Eyes ☐Right Temple ☐Hatband region ☐Right side of head ☐Left Temple ☐All over ☐Left side of head ☐Both Temples Other: ____________________
5.	Are they preceded by vision loss, weakness or numbness?	☐Yes☐No If yes, describe: ____________________ ____________________
6.	Describe headache quality:	☐Throbbing ☐Tension ☐Shooting ☐Pressure ☐Sharp
7.	Are Headaches accompanied by:	
	a) Sparkles in vision?	☐Yes ☐No ☐Constantly ☐Occasionally
	b) Sensitivity to light?	☐Yes ☐No ☐Constantly ☐Occasionally
	c) Sensitivity to sound?	☐Yes ☐No ☐Constantly ☐Occasionally
	d) Nausea?	☐Yes ☐No ☐Constantly ☐Occasionally
	e) Vomiting?	☐Yes ☐No ☐Constantly ☐Occasionally
	f) Dizziness?	☐Yes ☐No ☐Constantly ☐Occasionally
	g) Blurred vision?	☐Yes ☐No ☐Constantly ☐Occasionally
8.	What relieves the headaches?	☐Nothing ☐Medication ☐Ice ☐Rest ☐Darkness
9.	How long do the headaches last?	____________________

JAW PAIN

1.	Have you experienced jaw pain since accident?	☐Yes ☐No ☐Constantly ☐Occasionally	How often?_________
2.	Have you experienced:	☐Pain when chewing ☐Popping ☐Clicking ☐Locking	Other: ____________
3.	What relieves the pain?	☐Nothing ☐Medication ☐Soft diet ☐Splint	

JOINT PAIN

1.	Have you experienced joint pain since accident?	☐Yes ☐No ☐Constantly ☐Occasionally	How often?_________
2.	How bad is the pain? (Level 10 being the highest)	☐1/10 ☐2/10 ☐3/10 ☐4/10 ☐ 5/10 ☐6/10 ☐7/10 ☐8/10 ☐9/10 ☐ 10/10	Range_____/10
3.	Where is the pain located?	☐R ☐L Shoulder ☐R ☐L Hip ☐R ☐L Elbow ☐R ☐L Knee ☐R ☐L Wrist ☐R ☐L Ankle ☐R ☐L Hand ☐R ☐L Foot Other: ____________	
4.	Is there limitation of motion?	☐Yes ☐No	
5.	What makes it worse?	☐Range of motion ☐Sitting ☐Activities of daily living ☐Weight bearing ☐Bending ☐Standing ☐Lying on side ____________	
6.	What makes it better?	☐Nothing ☐Injections ☐Heat ☐Rest ☐Chiropractic ☐Ice ☐Medication ☐Physical therapy	

NECK PAIN

1.	Have you experienced neck pain since accident?	☐Yes ☐No ☐Constantly ☐Occasionally	How often?_________
2.	How bad is the pain? (Level 10 being the highest)	☐1/10 ☐2/10 ☐3/10 ☐4/10 ☐ 5/10 ☐6/10 ☐7/10 ☐8/10 ☐9/10 ☐ 10/10	Range_____/10
3.	Where does the pain radiate?:	☐R ☐L Shoulder ☐R ☐L Arm ☐R ☐L Hand Other:	
4.	Where is numbness/tingling located?	☐R ☐L Shoulder ☐R ☐L Arm ☐R ☐L Hand ☐Intermittent ☐ Constant ____________	
5.	Where is weakness located?:	☐R ☐L Shoulder ☐R ☐L Arm ☐R ☐L Hand ☐Intermittent ☐ Constant ____________	
6.	What makes it worse?	☐ Nothing ☐ Weight bearing ☐ Bending ☐ Range of motion ☐ Standing ☐ Lying on side ☐ Overhead reaching ☐ Sitting ☐ Activities of daily living Other: ____________	
7.	What makes it better?	☐Nothing ☐Injections ☐Heat ☐Traction ☐Rest ☐Chiropractic ☐Ice ☐Medication ☐Physical therapy ☐Stretching ☐Other:	

MID BACK PAIN

1.	Have you experienced mid-back pain since accident?	☐Yes ☐No ☐Constantly ☐Occasionally	How often?__________
2.	How bad is the pain? (Level 10 being the highest)	☐1/10 ☐2/10 ☐3/10 ☐4/10 ☐ 5/10 ☐6/10 ☐7/10 ☐8/10 ☐9/10 ☐ 10/10	Range______/10
3.	Where does the pain radiate?	☐No ☐Across ribcage ☐Across shoulder blades ☐Around waist Other:	
4.	Where is numbness/tingling located?	☐No ☐R ☐L Ribcage ☐R ☐L Flank Other:	
5.	What makes it worse?	☐ Nothing ☐ Weight bearing ☐ Bending ☐ Range of motion ☐ Standing ☐ Lying on side ☐ Overhead reaching ☐ Sitting ☐ Activities of daily living Other:	
6.	What makes it better?	☐Nothing ☐Injections ☐Heat ☐Traction ☐Rest ☐Chiropractic ☐Ice ☐Medication ☐Physical therapy ☐Stretching ☐Other:	

LOW BACK PAIN

1.	Have you experienced low back pain since accident?	☐Yes ☐No ☐Constantly ☐Occasionally	How often?_________
2.	How bad is the pain? (Level 10 being the highest)	☐1/10 ☐2/10 ☐3/10 ☐4/10 ☐ 5/10 ☐6/10 ☐7/10 ☐8/10 ☐9/10 ☐ 10/10	Range_____/10
3.	Where does the pain radiate?	☐R ☐L buttock ☐R ☐L leg ☐R ☐L foot Other:	
4.	Where is numbness/tingling? located?	☐R ☐L buttock ☐R ☐L leg ☐R ☐L foot ☐Intermittent ☐ Constant	
5.	Where is weakness located?:	☐R ☐L buttock ☐R ☐L leg ☐R ☐L foot ☐Intermittent ☐ Constant	
6.	What makes it worse?	☐ Nothing ☐ Weight bearing ☐ Bending ☐ Range of motion ☐ Standing ☐ Lying on side ☐ Overhead reaching ☐ Sitting ☐ Activities of daily living Other:	
7.	What makes it better?	☐Nothing ☐Injections ☐Heat ☐Traction ☐Rest ☐Chiropractic ☐Ice ☐Medication ☐Physical therapy ☐Stretching ☐Other:	

BOWEL BLADDER SYMPTOMS

Have you noticed loss of bowel or bladder control since the accident?	☐Yes ☐No ☐Constantly ☐Occasionally How often?_____________ ☐Incomplete Voiding ☐Urgency Please describe: ____________________ ____

SEXUAL DYSFUNCTION

Have you had sexual problems since the accident?	☐Yes ☐No ☐Constantly ☐Occasionally ☐Loss of desire ☐Difficulty with arousal ☐Difficulty achieving orgasm ☐Other

DIZZINESS

1.	Have you had dizziness?	☐Yes ☐No ☐Constantly ☐Occasionally How often: ________
2.	Have you had lightheadedness?	☐Yes ☐No ☐Constantly ☐Occasionally How often: ________
3.	Have you felt the room spin?	☐Yes ☐No ☐Constantly ☐Occasionally How often: ________
4.	Have you felt off balance?	☐Yes ☐No ☐Constantly ☐Occasionally How often: ________
5.	Do you feel off balance only with headaches?	How often: ________________
6.	How long does the dizziness last?	Duration: ________________
7.	Dizziness is accompanied by:	☐No other symptoms ☐Excessive sweating ☐Anxiety ☐Heart palpitations ☐Ringing of ears Other:
8.	What triggers the dizziness?	☐Quick movements ☐Standing suddenly ☐Driving ☐Loud noises ☐Rolling over ☐Stress Other: ________________

SEIZURES

1.	Have you had any seizures since accident?	☐Yes ☐No How often?________
2.	How many?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20
3.	Please describe:	☐Loss of consciousness ☐Automatic repetitive movements ☐Staring spells ☐Involuntary shaking/jerking Other: ________________
4.	Any prior history of seizures?	☐Yes ☐No ☐Other: ________________
5.	What did you feel before the seizure(s)?	☐ Nothing ☐ Feeling faint ☐ Excess sweating ☐ Aura perception ☐ Nausea ☐ Chest pain Aura Description: ________________
6.	What accompanied them?	☐Nothing ☐Bowel incontinence ☐ Tongue biting ☐Loss of awareness ☐Bladder incontinence ☐Self-injury ☐No loss of awareness Other:
7.	Were they followed by a period of confusion?	☐Yes ☐No How Long? ________________

HEARING LOSS

1.	Have you had any hearing loss since the accident?	☐Right ☐Left ☐No ☐Constantly ☐Occasionally How often?______
2.	Is your hearing muffled?	☐Right ☐Left ☐No ☐Constantly ☐Occasionally How often?______
3.	Have you had ringing in ears?	☐Right ☐Left ☐No ☐Constantly ☐Occasionally How often?______
4.	Have you had ear pain?	☐Right ☐Left ☐No ☐Constantly ☐Occasionally How often?______

MEMORY LOSS

1.	Have you had memory loss since the accident, with any of the following?	☐Yes ☐No ☐Constantly ☐Occasionally How often?__________
		☐Short-term memory loss ☐ Get lost in familiar places
		☐Misplace objects ☐Have to write things down to remember them
		☐Changes in personality
		☐Forgetfulness ☐Mental instability
		☐Impaired concentration ☐Impulsiveness
		☐Impaired multi-tasking ☐Mood Swings

MEDICAL HISTORY – **Please list all current or past medical conditions –NOT RELATED TO THE INJURY**

1.	Check any current illnesses: ☐ ADD/ADHD ☐ Alzheimer's disease/Dementia ☐ Anemia ☐ Aneurysm ☐ Anxiety ☐ Arthritis ☐ Atrial fibrillation ☐ Bipolar disorder ☐ Bleeding disorder ☐ Brain tumor ☐ Cancer ☐ Carpal tunnel syndrome ☐ Chronic hepatitis	☐ Congestive heart failure ☐ COPD/Emphysema ☐ Deep vein thrombosis ☐ Depression ☐ Diabetes ☐ Drug dependency ☐ Epilepsy ☐ Fibromyalgia ☐ Gastritis ☐ GERD ☐ Fracture	☐ Heart attack ☐ Heart disease ☐ Hemophilia ☐ High cholesterol ☐ HIV ☐ Hypertension ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Insomnia ☐ Irritable bowel syndrome ☐ Joint injury ☐ Kidney stone ☐ Kidney failure ☐ Liver failure ☐ Migraines/Headaches	☐ Multiple sclerosis ☐ Muscular dystrophy ☐ Neuropathy ☐ Parkinson's disease ☐ Peptic ulcer disease ☐ Prior back condition ☐ Prior neck condition ☐ Psoriasis ☐ Scoliosis ☐ Sleep apnea ☐ Stroke ☐ Surgical repair
2.	Have you ever been injured in the past?	☐Yes ☐No ☐Don't Recall If yes, please give details: ____________________ ____________________ ____________________		
3.	* FEMALES ONLY * Are you pregnant or planning pregnancy?	☐Yes ☐No Explain: ____________________ ____________________		
4.	Please list prior surgeries:	____________________ ____________________ ____________________ ____________________ ____________________		

ARE YOU ALLERGIC TO ANY MEDICATIONS? Please list all medications:______________________

____

Pharmacy Phone #: ( )

CURRENT MEDICATIONS -- List all medications you are currently taking

	Name	How much	How often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

FAMILY ILLNESSES -- Check serious illnesses of your immediate family

☐ ADD/ADHD	☐ Diabetes mellitus	☐ High cholesterol	☐ Muscular dystrophy
☐ Alzheimer's disease/Dementia	☐ Epilepsy	☐ Hypertension	☐ Neuropathy
☐ Anemia	☐ Eye disease (Glaucoma/Cataracts)	☐ Inflammatory bowel disease	☐ Parkinson's disease
☐ Brain aneurysm	☐ Hearing loss	☐ Kidney failure	☐ Psychiatric illness
☐ Brain tumor	☐ Heart attack (before age 40)	☐ Lung disease	☐ Rheumatoid arthritis
☐ Cancer	☐ Heart disease	☐ Lupus	☐ Scoliosis
☐ Carpal tunnel syndrome		☐ Migraines/Headaches	☐ Skin disease
☐ Colon polyps			☐ Stroke
☐ Other: _______________			☐ Thyroid disease

SOCIAL HISTORY / PAST HISTORY

1.	Do you smoke?	☐Yes ☐No Amount? ________________ Number of years? _____________
2.	Do you drink alcohol?	☐Yes ☐No Amount? ____
3.	Marital Status?	☐Single ☐Married ☐Divorced ☐Widowed
4	Do you have children?	☐Yes ☐No How many? ____
5.	Any change in exercise habits, hobbies or social activities following the injury?	Please explain: ____
6.	Were you employed at the time Of the accident?	☐Yes ☐No If yes, which type of work?______________________________
7.	Did you miss any days of work Due to this accident/injury?	☐Yes ☐No How many? ____
8.	Are you currently employed?	☐Yes ☐No If yes, which type of work?______________________________
9.	Education	☐GED ____ Highest grade completed ☐High school graduate ☐AA or AS degree ☐BA or BS degree ☐Master's ☐ Doctorate ☐ No degree __ Years college

Review of Systems – ***PLEASE CHECK IF YOU HAVE ANY OF THESE CURRENT SYMPTOMS***

YES	NO	
		Blurred Vision
		Blindness
		Double Vision
		Hearing Loss
		Ringing In The Ears
		Temporomandibular Joint Dysfunction (Jaw) Pain
		Loss Of Smell
		Loss Of Taste
		Difficulty Chewing
		Difficulty Swallowing
		Difficulty Speaking
		Difficulty Reading
		Memory Loss
		Headaches
		Change In Menstrual Cycle
		Menopause
		Impaired Sexual Function
		High Cholesterol
		Cough
		Shortness Of Breath
		Chest Pain
		Palpitations
		High Blood Pressure
		Diabetes
		Stroke
		Seizures

YES	NO	
		Loss Of Consciousness
		Dizziness
		Loss Of Balance
		Trouble Walking
		Difficulty Standing
		Trouble Falling Asleep
		Trouble Staying Asleep
		Panic Attacks
		Feeling Stress
		Nervousness
		Loss Of Interest In Activities
		Depression
		Weight Loss
		Weight Gain
		Weakness
		Numbness Or Tingling
		Joint Pain Or Swelling
		Swelling Of The Ankles
		Skin Rash Or Lesions
		Stomach Pain
		Heartburn
		Change In Bowel Habits
		Loss Of Bladder Control
		Loss Of Bowel Control
		Blood In Sputum
		Blood In Stools
		Fever Or Chills