Patient Questionnaire – Other-Accident

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

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: _____

_____

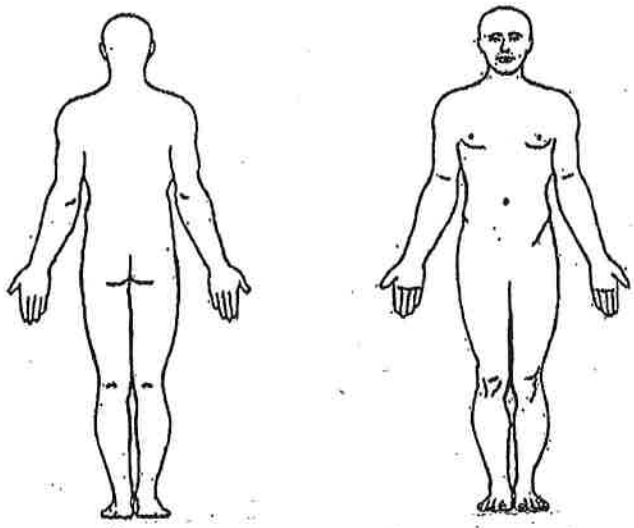
_____

_____

Describe the condition or symptoms caused by the Accident: _____

_____

Indique en la imagen donde le duele:



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 indicate any other healthcare providers/Emergency room/Urgent Care facilities that you have seen for these conditions or symptoms:

Name	Type of Physician/ER	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: _____

_____

X_____
Signature of patient or authorized representative

_____
Date