ACCIDENT/INJURY QUESTIONNAIRE

Patient Name: ____________________________________ Date: _________________

A. Date and Time of Accident/Injury: Date: ___/___/___ Time: ______ AM PM

B. Briefly describe accident/injury:

____

____

____

C. Immediately after the accident/injury

Did you lose consciousness?: ___Yes ___No ___Don't Know

How did you feel?: ___Confused ___Dazed ___Dizzy ___Nervous ___Weak

Other ____

Did you have immediate pain?: ___Yes ___No

If yes, where?____

Did you have lacerations (cuts)?: ___Yes ___No

If yes, where?____

D. Did you receive emergency care at the scene?: ___Yes ___No

If yes, what type of care?:____

E. Did you go to the hospital?: ___Yes ___No

If yes, give name of hospital & date of visit:____ ____________________________

Were x-rays, CT Scans, MRI taken?: ___Yes ___NO

If yes, what part of body?: ____

What treatment was administered?: ______________________________________

What instructions were given?: ____

Were medications prescribed?: ___Yes ___NO

If yes, what type?: ____

F. Have you missed work due to accident/injury?: ___Yes ___No

If yes, what dates?: ____

G. Did you seek medical care elsewhere, other than hospital?: ___Yes ___No

If yes, name and address of medical facility: ________________________________

____

H. Have you contacted an insurance adjuster? ___Yes ___No

If yes, name of insurance company: _______________________________________

I. Have you engaged services of an attorney?: ___Yes ___No

If yes, give name and address of attorney: ___________________________________