Accident/Injury Questionnaire

Name_____

1. Todays date: _____

2. Date of Injury: _____

3. Please describe in your own words what happened._____
_____
_____

4. Immediately after the accident where did you develop pain?

- ❑ **Head**
- ❑ **Neck**
- ❑ **Upper Back**
- ❑ **Mid back**
- ❑ **Low back**
- ❑ **Pelvis**
- ❑ **Chest**
- ❑ **Rib Cage**
- ❑ **Abdomen**
- ❑ **Left upper Extremity**
- ❑ **Right Upper Extremity**
- ❑ **Left Lower Extremity**
- ❑ **Right Lower Extremity**

5. Have you received treatment as a result of this injury? **Yes** **No**

6. If so, what treatment have you received?
_____
_____
_____

7. Has this accident caused you to miss any work?
Yes *Please give dates:*_____
No

Patient or Guardian Signature:_____ **Date:**_____