ACCIDENT / WORKERS' COMPENSATION QUESTIONNAIRE

Patient: ________________________________ Date: ______________

Date of Accident:____________________ Hour: _____AM _____PM Location:_________________________
How did accident occur? ☐ Auto Collision ☐ On-the-job Injury ☐ Other:________________________________
If not an auto collision, please describe the circumstances:____
____
____
Did you report the injury to your foreman or employer? ☐ Yes ☐ No
If auto accident, were you: ☐ Driver ☐ Passenger ☐ Pedestrian
If Passenger, were you sitting in: ☐ Front ☐ Right Rear ☐ Left Rear
If auto collision, were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked
Were you wearing a seatbelt? ☐ Yes ☐ No Did the airbag release? ☐ Yes ☐ No
Did your car strike the other(s) involved? ☐ Yes ☐ No
Did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined
What type of car were you in?____________________________ The other person?_________________________
How fast were you going when hit?________________ How fast was the other car going?________________
At the time of impact were you: ☐ Looking straight ahead ☐ Looking right ☐ Looking left
Were both hands on the steering wheel? ☐ Yes ☐ No Was your foot on brake? ☐ Yes ☐ No
Did you see the other car before it hit you? ☐ Yes ☐ No Did you brace yourself? ☐ Yes ☐ No
Where in the car were you after the accident? ____
Did you strike anything in the vehicle at the time of impact? ☐ Yes ☐ No
If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests
☐ Side Window ☐ Other: ____
Please state part of body: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head
☐ Other: ____
Immediately following the accident, were you: ☐ Unconscious ☐ In a daze
Did you go to the hospital? ☐ Yes ☐ No If yes, when? ☐ At time of accident ☐ Next day
Name of hospital: ____
Name of doctor: ____
How did you get to the hospital? ☐ Ambulance ☐ Private Transportation
If ambulance, did the ambulance attendants place you in: ☐ Neck Collar ☐ Splints ☐ Brace
Were you x-rayed at hospital? ☐ Yes ☐ No
If yes, what was the diagnosis? ____
Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? ________________________
What treatment was rendered?____
What recommendations were made? ☐ See own doctor ☐ See orthopedic doctor ☐ Physical Therapy
☐ Medications ☐ No recommendations were given ☐ Other: __________________________
Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No
Doctor's name: ____
Others in vehicle:____
____

Patient: ______________________________ Date: ____________

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT OR INJURY:

□ Headache	□ Irritability	□ Numbness in Toes	□ Face Flushed	□ Feet Cold
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Buzzing in Ears	□ Hands Cold
□ Neck Stiff	□ Dizziness	□ Fatigue	□ Loss of Balance	□ Stomach Upset
□ Sleeping Problems	□ Head seems too heavy	□ Depression	□ Fainting Spells	□ Constipation
□ Back Pain	□ Pins & Needles in Arms	□ Light bothers Eyes	□ Loss of Smell	□ Cold Sweats
□ Nervousness	□ Pins & Needles in Legs	□ Loss of Memory	□ Loss of Taste	□ Fever
□ Tension	□ Numbness in Fingers	□ Ears Ring	□ Diarrhea	

Symptoms other than above:____

____

Have you lost any time from work because of this accident? □ Yes □ No

If yes, give dates of time lost: From __________ To __________

Totally disabled from __________ to __________ Partially disabled from __________ to __________

Do you feel that you can not perform any physical work activity? □ Yes □ No

Do you feel that you can not perform any mental work? □ Yes □ No

Relate your BEFORE injury capacity (mark "B") and your AFTER injury capacity (mark "A") for performing the following activities:

Activity	Normal	Limited	Difficult	Pain
1. Walking	Normal _____	Limited _____	Difficult _____	Pain _____
2. Standing	Normal _____	Limited _____	Difficult _____	Pain _____
3. Sitting	Normal _____	Limited _____	Difficult _____	Pain _____
4. Bending	Normal _____	Limited _____	Difficult _____	Pain _____
5. Stooping	Normal _____	Limited _____	Difficult _____	Pain _____
6. Lifting	Normal _____	Limited _____	Difficult _____	Pain _____
7. Pushing	Normal _____	Limited _____	Difficult _____	Pain _____
8. Pulling	Normal _____	Limited _____	Difficult _____	Pain _____
9. Climbing	Normal _____	Limited _____	Difficult _____	Pain _____
10. Reaching	Normal _____	Limited _____	Difficult _____	Pain _____
11. Gripping	Normal _____	Limited _____	Difficult _____	Pain _____
12. Kneeling	Normal _____	Limited _____	Difficult _____	Pain _____
13. Balance	Normal _____	Limited _____	Difficult _____	Pain _____
14. Fatigue	Normal _____	Limited _____	Difficult _____	Pain _____

Generally speaking, is your inability to perform these functions due to:

□ Pain □ Weakness □ Stiffness □ Nerves □ Other: ____

Do you have normal sexual function? □ Yes □ No

Are you able to take care of your personal self, such as dressing, bathing, etc.? □ Yes □ No

Do you feel your present condition is: □ Temporary □ Permanent

Patient's Signature ____ Date ____________________

Doctor's Signature ____

□ Ron Daulton, D.C. □ Ron Daulton, Jr., D.C., FICPA