

CoreHealth of Clearwater LLC
1501 S. Missouri Ave.
Clearwater, FL 33756
727-216-3216

Patient Name: _____
Date of Birth: _____

Accident/Injury Questionnaire

Date of Accident/Injury: _____ Time of Accident/Injury: _____am/pm

Type of Accident/Injury: (Circle) Automobile Crash (Skip to Next section) Workmen's Comp
Slip/Fall Pedestrian Accident Other:

What was the cause of your accident/injury?

Describe what happened:

Immediately after Accident/Injury (Circle)

Did you lose consciousness? Yes No Don't Know

How did you feel? Confused Dazed Dizzy Nervous Weak Other: _____

Did you immediately feel pain? Yes No If applicable indicate Right or Left:

Head Neck Upper/Mid Back Lower Back Pelvis Chest/Ribs Abdomen Shoulder (R or L)
Arms (R or L) Elbows (R or L) Forearms (R or L) Wrists (R or L) Hands (R or L) Buttocks (R or L)
Hips (R or L) Thighs (R or L) Knees (R or L) Legs (R or L) Ankles (R or L) Feet (R or L)

Did you have any cuts? Yes No If applicable indicate Right or Left:

Head Neck Upper/Mid Back Lower Back Pelvis Chest/Ribs Abdomen Shoulder (R or L)
Arms (R or L) Elbows (R or L) Forearms (R or L) Wrists (R or L) Hands (R or L) Buttocks (R or L)
Hips (R or L) Thighs (R or L) Knees (R or L) Legs (R or L) Ankles (R or L) Feet (R or L)

Describe any other injury: _____

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Did you receive emergency care? Yes or No
What type of Emergency Care? Bandages Splints Brace Neck Collar Other: _____
Where did you go after the Accident/Injury? Hospital School Home Work Other: _____
Who drove you? Myself Ambulance Friend Family Member Other: _____

Hospital Visit After Accident/Injury

When did you go to the hospital? Immediately Later That Day Next Day Days Later
Date: _____
Hospital Name: _____
Exam Doctor: _____
Were you admitted? Yes or No Date: _____
What imaging was performed? X-ray MRI CAT Scan Other: _____
What body area(s)? _____

What diagnosis was given? (Circle)
Sprain Strain Fracture Concussion Disc Injury Dislocation Laceration Contusion

What treatment was administered at hospital? (Circle)
Oral Medication Injection Topical Antiseptics Sutures Bandages Brace Splint Cast Collar
Surgery Ice packs Heat packs Other: _____

What recommendations were made? (Circle)
No Further Care No Instructions Given Observation Rest Ice Heat Collar Support
Time Off Work Other: _____

What medications were prescribed? (Circle)
Pain Anti-Inflammatory Antibiotic Anxiety Other: _____

Following Accident/Injury

When did additional symptoms develop? (Circle) Immediately Hours Later That Evening Next
Morning Days Later Week Later Month Later Other: _____
What additional symptoms developed? _____
Where did the additional symptoms develop? _____

Since your accident injury have you had: Blurred Vision Double Vision Reduced Vision
Impaired Hearing Ringing in Ears Chest Pain Difficulty Breathing Palpitations Constipation
Diarrhea Nausea Vomiting Frequent Urination Inability To Hold Urine Painful Urination
Other: _____

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Have you experienced any of the following?: (Circle) Anxiety Depression Mood Swings
Nervousness Poor Memory Tension Convulsions Dizziness Headaches Fainting
Loss of Balance Fatigue Restlessness Insomnia Light Sensitivity Reduced Appetite
Weakness Weight Gain Weight Loss Other: _____

Are any of the following restricted as a result of your accident? (Circle) Daily Living Occupation/Work
Recreational Activities Other: _____

Have you missed work due to this Accident/Injury? (Circle) Not Missed Work Limited Work Activity
Missed work dates: From _____ To _____

What have you done at home to treat your symptoms? (Circle) Ice Heat Bed Rest
Over the Counter Medication Other: _____

Other Doctors You Have Seen For This Accident/Injury:

Physician Name: _____
Specialty: _____
City: _____ State: _____
Diagnosis and Treatment Recommended: _____

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Specialty: _____
City: _____ State: _____
Diagnosis and Treatment Recommended: _____

Physician Name: _____
Specialty: _____
City: _____ State: _____
Diagnosis and Treatment Recommended: _____

Have you had any of the following tests? (Circle) MRI CT Electrodiagnostic Studies