



Franklin Back & Joint Care

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38 Pond Street, #206

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296 Main Street

Franklin, MA 02038

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Milford, MA 01757

ACCIDENT QUESTIONNAIRE

Name _____ Social Security # _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Age _____ Birthdate _____ Marital Status: M S W D

Employer _____ Work Phone _____ Children # _____

Email Address (to receive our Health newsletter): _____

Your Primary Care Physician _____

Is it OK if we submit your findings to your primary care physician? **YES** **NO**

Accident Information

Date & Time injury occurred: **MONTH:** _____ **DAY:** _____ **YEAR:** _____ **TIME:** _____

Give brief details of how your accident occurred: _____

Have you retained an attorney?..... **YES** **NO**

If an attorney is retained, give full name: _____

Address & Phone#: _____

Your Insurance Co: _____

Phone # _____ Claim# _____

Name of Your Insurance Adjuster: _____

Name of driver of vehicle in which you were injured _____

His/Her Insurance Co _____ Policy # _____

Name of Other Party Involved _____

Their Insurance Co: _____ Policy # _____

Number of occupants in your vehicle: _____ Have they sought care for their injuries: _____

Were the police notified: _____ Were you knocked unconscious: _____

Did you SEE the impending impact: _____ Was your head turned when you were hit: _____

Did you brace yourself: _____ Were you able to get out of the car: _____

Model/Year of YOUR car: _____ Model/Year of other car: _____

Your approx. speed at impact: _____ Other car's approx. speed: _____

Did your body hit any area of the car: _____ Did your airbag deploy: _____

Did you have on your seatbelt: _____ Did your seat break: _____

Which hand(s) did you have on your steering wheel when you got hit: **RIGHT** **LEFT** **BOTH**

Treatment Information:

When did symptoms of this accident first appear? _____

Have any other doctors been seen for this condition? _____

What hospital were you taken to: _____

What treatment, if any, did you receive? _____

Were xrays taken? _____

What makes your pain worse (ex: bending, lifting, sitting): _____

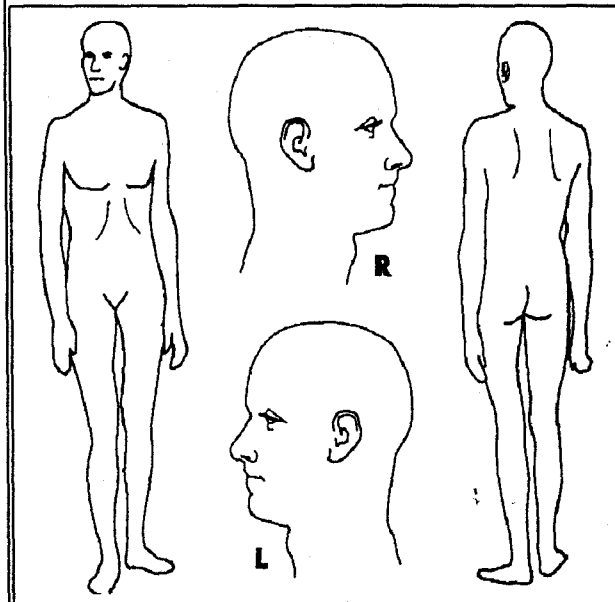
What makes your pain better (ex: heat, stretch, advil): _____

Health Survey

Please check off all symptoms that have been caused from this accident:

| Cardiovascular | Musculoskeletal | Nervous System | Ears, Eyes, etc |
|--|---|---|--|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low back pain | <input type="checkbox"/> numbness | <input type="checkbox"/> eye strain |
| <input type="checkbox"/> rapid heart beat | <input type="checkbox"/> pain b/t shoulders | <input type="checkbox"/> paralysis | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> difficult breathing | <input type="checkbox"/> neck pain | <input type="checkbox"/> dizziness | <input type="checkbox"/> ear pain |
| <input type="checkbox"/> persistent cough | <input type="checkbox"/> arm problems | <input type="checkbox"/> fainting | <input type="checkbox"/> ear noise |
| <input type="checkbox"/> coughing blood | <input type="checkbox"/> leg problems | <input type="checkbox"/> headaches | <input type="checkbox"/> hearing loss |
| | <input type="checkbox"/> swollen joints | <input type="checkbox"/> muscle jerking | <input type="checkbox"/> nose pain |
| | <input type="checkbox"/> stiff joints | <input type="checkbox"/> forgetfulness | <input type="checkbox"/> nose discharge |
| | <input type="checkbox"/> sore muscles | <input type="checkbox"/> confusion | <input type="checkbox"/> difficult breathing |
| | <input type="checkbox"/> broken bones | <input type="checkbox"/> depression | <input type="checkbox"/> sore gums |
| | <input type="checkbox"/> weak muscles | <input type="checkbox"/> depression | <input type="checkbox"/> dental problems |
| | <input type="checkbox"/> foot problems | | <input type="checkbox"/> difficult speech |
| | <input type="checkbox"/> ruptures | | |

Please mark areas of pain resulting from this accident on the figures below and then answer the questions below:



Pain Questions:

On a scale of 0-10 (10 being worst), how would you rate your symptoms today? _____

Describe your pain (circle all that apply):

- | | | |
|----------|----------|-------|
| Sharp | Dull | Numb |
| Tingling | Throb | Achy |
| Sore | Shooting | Stiff |

Health Status:

Your height and weight: _____

Do you smoke: _____

Do you exercise: _____

I, the patient, have completed this form to the best of my knowledge and truthfulness in regards to the personal injury I have sustained.

Patient Signature: _____ Date: _____