Advanced Healthcare Center
Health Questionnaire

ACCIDENTAL INJURY REPORT

Name_____Today's date_____
Date of Accident_____Time of Accident_____AM PM
Location of Accident_____
Type of Accident:_____Auto/Traffic_____Work/On Job_____At home Other
_____
Describe how the accident happened in your own words:_____
_____
_____
_____
Immediately following the accident, how did you feel?_____
_____
How did you feel the next day?_____
Were you unconscious?_____Yes _____No In a daze? ____Yes _____No
Did you go to the hospital? _____Yes _____No If you went to the hospital when? At time of accident _____Yes _____No Next day_____ Other_____ How did you get to the hospital? Ambulance _____Yes _____No Private Transportation _____Yes _____No
Did the ambulance attendants place you in: Neck Collar_____Yes _____No
Splints _____Yes _____No Brace Yes_____ No_____
Name of Hospital _____ attended by Dr._____
Were you x-rayed at hospital? _____Yes _____No If so, what was the diagnosis?_____
Were you admitted to the hospital? _____Yes _____No If so, How long did you stay? _____ What treatment was rendered? _____
What recommendations were made? _____
List any other doctors you have seen as a result of this accident:_____
_____
Have you lost any time at work because of this accident? _____ _Yes_____ No_____
If yes, give dates of disability: Totally disabled from _____ to _____ have you returned to work since the accident? _____Yes _____No Please complete the following:
Date Employer Occupation Light/reg.duty full-part time
_____
_____
_____

Since this accident occurred, are your symptoms: Improving_____ Getting worse____Same _____ Do you notice any activity restrictions as a result of this injury? Yes_____
No_____ Please describe_____
_____
Have you been contacted by an insurance adjuster or company representative about this accident? _____ Yes _____ No If so, name, phone # or person contacting

you:_____ Have you retained an attorney _____ Yes _____ No
Date attorney retained or to be retained: _____ Attorney's name: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip: _____ Please complete the questions on the next page in accident category

AUTO/TRAFFIC ACCIDENT
Was the accident reported to Police Department? _____ Yes _____ No
Number of people in the car? _____ Were traffic citations issued, If so, to whom _____ Were you a _____ driver ____ pedestrian _____ passenger were you sitting in _____ front _____ right rear_____ left rear Did your vehicle hit other vehicle(s)? _____ Yes _____ No Estimated speed of your vehicle at impact _____MPH. Was your vehicle hit by another vehicle? ____Yes _____ No Estimated speed of other vehicle at impact? _____MPH Was the impact from the front _____ from the right or left side _____ from the rear _____ What kind of vehicle hit your's? ____ truck _____ car ____ other. Were you wearing seat belts? Yes ___ No____ Did you strike anything in the vehicle at the time of accident? _____ Yes _____ No if yes, specify: _____ steering wheel _____ dashboard _____ arm rests _____ Please state part of body: ____chest ____ chin ____knee____other

VEHICLE YOU WERE IN	OTHER VEHICLE
Driver _____	Driver _____
Insured _____	Insured_____
Address_____	Address_____
Phone_____	Phone_____
Insurance Co._____	Insurance Co._____
Ins. Co. Address_____	Ins. Co. Address_____
Adjuster_____	Adjuster_____
Phone_____	Phone_____
Policy #_____	Policy #_____
Claim #_____	Claim #_____

Have you been contacted by a claim representative? _____
Date contacted _____ By:_____
Your insurance Agent's name/phone #:_____
Have you contacted your Insurance Company?_____

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WORK ON JOB ACCIDENT

List any equipment, machinery and/or object related to the accident:_____

Was the accident reported to the supervisor or employer?_____
If so, to whom:_____ Has a worker's compensation claim been filed? _____ Yes _____ No Insurance carrier_____

Name and Office Phone # of your immediate supervisor/foreman:_____

Type of work being done at time of injury:_____

Length of time you have worked there prior to accident:_____

Have you been injured before? _____Yes _____No

Job title/Activity:_____
_____

In a typical 8-hour workday, I (circle # of hours/Activity)
Sit 1 2 3 4 5 6 7 8 hours; Stand; 1 2 3 4 5 6 7 8 hours,
Walk 1 2 3 4 5 6 7 8 hours. Mark those that apply: On the job I ____ bend ____stoop ____ squat ____ crawl ____ reach above head ____ Kneel ____ Push ____ Pull ____ How often:_____
I lift up to: _____Lbs. How often: _____

Patient's Signature: _____ Date_____