NorthPark
Medical Group
Total care under one roof

ACCIDENT / INJURY QUESTIONNAIRE

Title: _____ First:_____ MI:____ Last:_____

Date of accident: _____ Time of accident: _____ _____ am/pm :

Type of accident: ☐ Automobile Accident (skip to next section and fill out Auto Accident Questionnaire)

☐ Worker's Compensation Accident/Injury ☐ Slip/Fall Accident ☐ Pedestrian Accident

Other Accident:_____Other Injury:_____

What was the cause of your accident / injury:_____

_____

_____

Describe in your own words what happened:_____

_____

_____

IMMEDIATELY AFTER ACCIDENT / INJURY

Did you lose consciousness? ☐ Yes ☐ No Unknown

How did you feel (check all that apply):

☐ Confused ☐ Dazed ☐ Dizzy ☐ Nervous ☐ Weak ☐ Other:

Where did you immediately develop PAIN : ☐ or have lacerations/CUTS ○ (check all that apply):

Cuts	Pain		Cuts	Pain		Cuts	Pain		Cuts	Pain		Cuts	Pain	
○	☐	Head	○	☐	Neck	○	☐	Upper/Mid Back	○	☐	Lower Back	○	☐	Pelvis
○	☐	Abdomen	○	☐	Shoulders	○	☐	Chest/Rib Cage	○	☐	Arms	○	☐	Elbows
○	☐	Forearms	○	☐	Wrists	○	☐	Hands	○	☐	Buttocks	○	☐	Hips
○	☐	Thighs	○	☐	Knees	○	☐	Legs	○	☐	Ankles	○	☐	Feet
○	☐	Other:				○	☐	Other:						