AIC ADVANCED INJURY • CARE

Advanced Injury Care Health Questionnaire

Nature of Accident

Name: _____

Date: _____

Date of Accident/Injury: _____ **Were you struck from the (circle one):** Rear Front Left Side Right Side

Approximate speed of your vehicle: _____ **Approximate speed of other car:** _____

Were you knocked unconscious? YES NO

In your own words, please describe the accident/injury: _____

_____

Did you have any physical complaints before the accident/injury? YES NO

If yes, please describe in detail: _____

What are your PRESENT complaints and symptoms: _____

_____

Do you have any previous illnesses which relate to this cause? YES NO

If yes, please describe in detail: _____

Have you been treated by another doctor since this accident/injury? YES NO

If yes, please describe in detail: _____

Since the injury occurred, are your symptoms (circle one): Improving Worsening Same

Circle the symptom(s) you have noticed since the accidentt/injury?

Headache	Neck Stiffness	Constipation
Back Pain	Tension	Loss of Taste
Neck Pain	Fever	Diarrhea
Hands Cold	Loss of Balance	Upset Stomach
Depression	Fatigue	Memory Loss
Ears Ringing	Loss of Smell	Numbness in Fingers
Knee Pain	Sleeping Problems	Chest Pain
Shoulder Pain	Irritability	Head Seems Too Heavy
Ankle Pain	Shortness of Breath	Arm Weakness
Elbow Pain	Dizziness	Leg Weakness
Numbness in Toes	Nervousness	Pins and Needles in Arms
Sensitivity to Lights	Buzzing in Ears	Pins and Needles in Legs

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Advanced Injury Care Health Questionnaire

Nature of Accident Continued

Name: _____

Date: _____

Do you notice any activity restrictions as a result of this injury? YES NO

If yes, please describe in detail: _____

Have you had surgery on the area being scanned? YES NO

If yes, please describe in detail: _____

Have you had prior diagnostic testing (X-rays, CT, MRI , on the area being scanned? YES NO

If yes, list facility, dates and exam type: _____

Have you had any previous surgeries? YES NO

If yes, please describe in detail: _____

Do you have any medical allergies? YES NO

If yes, list: _____

Are you on any medications? YES NO

If yes, list: _____ _____