INNOVATIVE
SPINE CARE

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www.GotSpinePain.com

Patient Questionaire

PATIENT NAME: _____

DATE OF ACCIDENT: _____/_____/_____LOCATION OF ACCIDENT: _____

Describe The Accident In Your Own Words: _____

_____

_____

Were You Knocked Unconscious? YES NO If yes, Ho how long were you unconscious?_____

Did You Feel Pain Immediately? YES NO If yes, where did you feel pain? _____

Did You Go To Hospital? YES NO If yes, where did you stay? _____

Were Xrays Taken? YES NO

Were Mri'S Taken? YES NO

Were Ct Scans taken? YES NO

Were Medications Given? YES NO If yes, what medications did you take? _____

What Was Your Diagnosis? _____

Have You Been Treated By Another Physician Since The Accident? Yes No

(If you have been treated by another physician, please fill in the Doctor's information below and circle any specialties that apply.)

DR NAME: _____ MD DC PT ORTHO PHONE: _____

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Did You Have Symptoms Prior To The Accident? YES NO

Please circle the term that best describes your current symptoms? SAME WORSE IMPROVING

Were you wearing a seatbelt? YES NO

Were you the Driver or a Passenger? _____

If you were the passenger, where you sitting in the front or rear of the vehicle? _____

Where was the vehicle struck? FRONT REAR DRIVERS SIDE PASSEGER OTHER: _____

Have you ever been in an auto accident before? YES NO

If you have been in a previous accident, please list the date(s) and any injuries you may have sustained:

_____

_____

_____