✖exer URGENT CARE™

Personal Injury Questionnaire

Today's Date: ________________ Patient's Age: ______ Sex at Birth: ☐ Male ☐ Female

Patient First Name: _________________________ Last Name: _____________________________

Accident Details - Date of accident ___________

In the accident, were you:

☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger ☐ Other: __________

Your vehicle was: ☐ Stopped ☐ Moving ☐ Starting ☐ Slowing Down

Approximate speed of your vehicle: ☐ MPH

Force of impact: ☐ Mild ☐ Moderate ☐ Severe

Were you struck from: ☐ Behind ☐ Front ☐ Left ☐ Right

Were you wearing a lap and shoulder belt? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

Did you hit/strike any part of your body against the car/vehicle? ☐ Yes ☐ No

If yes, please describe: ____

Did you lose consciousness/black out? ☐ Yes ☐ No ☐ Unsure

If yes, for how long? ____

Were the police notified? ☐ Yes ☐ No

If yes, did you get a copy of the police report? ☐ Yes ☐ No

In your own words, describe the accident: ____

____

Injury Details

Did you have any physical complaints BEFORE the accident? ☐ Yes ☐ No

If yes, describe in detail: ____

Did you experience any of the following? (Check all that apply)

☐ Dazed ☐ Vomiting ☐ Dizziness ☐ Lightheadedness

☐ Nausea ☐ Headache ☐ Numbness ☐ Pain ☐ Blurred Vision

If you had pain immediately, please describe where: ______________________________________

Did you experience pain? ☐ Hours Later ☐ The Next Day ☐ Days Later

If so, where? ____

Is your pain worsening with coughing, sneezing, or straining? ☐ Yes ☐ No

If yes, please describe where it hurts: ____

After the accident, did you experience any of the following:

Bleeding: ☐ Yes ☐ No If yes, where: ____

Bruising: ☐ Yes ☐ No If yes, where: ____

Swelling: ☐ Yes ☐ No If yes, where: ____

Symptom Checklist

Have your symptoms caused any difficulty with the following? (Check all that apply)

☐ Work ☐ Sleep ☐ Exercise ☐ Driving ☐ Home Life

What symptoms have you noticed since the accident? (Check all that apply)

☐ Neck pain	☐ Neck Stiffness	☐ Upper Back Pain	☐ Lower Back Pain
☐ Mid Back Pain	☐ Pain Between Shoulders	☐ Pain Across Shoulders	☐ Head Feels Heavy
☐ Shortness of Breath	☐ Difficulty Swallowing	☐ Jaw Pain	☐ Light Bothering Eyes
☐ Blurred Vision	☐ Ringing in the Ears	☐ Dizziness	☐ Poor Concentration
☐ Depression	☐ Fatigue	☐ Irritability	☐ Nervousness
☐ Insomnia	☐ Loss of Memory	☐ Loss of Smell	☐ Loss of Taste
☐ Cold Sweats	☐ Cold Hands	☐ Cold Feet	☐ Pain in Hands
☐ Pain Down Arm	☐ Pain Down Leg	☐ Leg Cramps	
☐ Pins & Needles in Hand/Arm		☐ Weakness in Grip/Hand/Arm	

Pain Description

Issue 1

I currently have pain in my: ____

The pain began: ☐ Immediately ☐ Hours Later ☐ Days Later

The pain is: ☐ Getting Better ☐ Same ☐ Getting Worse

I would rate this condition on the following scale:

(No Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Severe pain)

The pain feels: ☐ Dull ☐ Sharp ☐ Aching ☐ Burning ☐ Stabbing

The pain gets better with: ____

The pain gets worse with: ____

Issue 2

I currently have pain in my: ____

The pain began: ☐ Immediately ☐ Hours Later ☐ Days Later

The pain is: ☐ Getting Better ☐ Same ☐ Getting Worse

I would rate this condition on the following scale:

(No Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Severe pain)

The pain feels: ☐ Dull ☐ Sharp ☐ Aching ☐ Burning ☐ Stabbing

The pain gets better with: ____

The pain gets worse with: ____