Tricity Pain Associates
Quality Care, Delivered.

PATIENT MEDICAL QUESTIONAIRE Motor Vehicle Accident

Please Print

Patient's Name: _____Date of Birth _____

SSN:_____ Date of Accident: _____

Please answer all questions. If it doesn't apply to you, please write N/A

How did the accident/injury happen? Also, please give street, city, state, intersection, weather conditions, etc. Please be specific.

_____

_____

_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Back seat passenger ☐ Pedestrian ☐Bicyclist ☐ Other _____

Were you wearing a seat belt at the time of the accident? Yes ☐ No ☐

What part of the body did you injure? (Please specify right or left).

_____

_____

What is your primary complaint today? _____

_____

If you are having neck or back pain are you having any bowel or bladder problems? Yes ☐ No ☐

Have you been treated for this injury? _____ If so, by whom? (list all Doctors, Hospitals)

_____

What type of treatment have you had for this injury? Please indicate what facility and the date.

X-rays _____ MRI _____

CT Scan _____ Injections _____

Physical Therapy _____ How many weeks/months of therapy have you had for this injury? Days _____ Weeks _____ Months _____