Trauma Questionnaire

Full Legal Name: _____ **Date:** _____

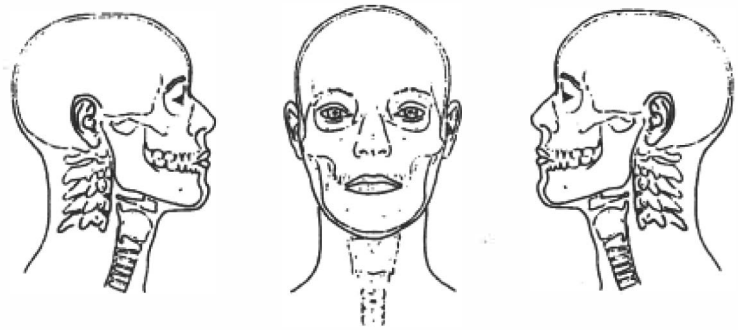
Please answer these questions to the best of your ability:

1. Date of Trauma (or respond "unknown"): _____
2. What was the cause of your trauma (circle one or more):
   - **Auto Accident**
   - **Physical altercation**
   - **Fall**
   - **Sports injury**
   - **Other**: _____
3. Provide more details on how the trauma happened:

   _____

   _____

   _____
4. On the diagram below, draw an arrow(s) to indicate the location(s) of your trauma and pain:



Left side **Front** **Right side**

5. During the trauma, did you strike your (circle all that apply):
   - **Skull**
   - **Nose**
   - **Chin**
   - **Lower Jaw**
   - **Neck**
   - **Chest**
   - **Other**: _____
6. Did you have whiplash (circle one): **YES** **NO**

GEORGIA DENTAL MEDICINE

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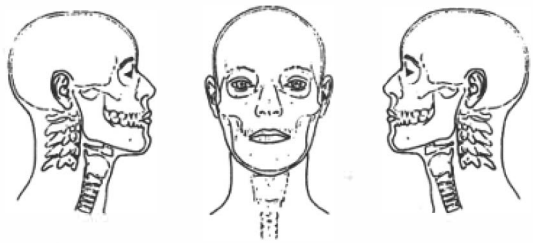
For Doctor Notes Below:



Left side **Front** **Right side**

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For Doctor Notes Below:

7. Which of the following visible injuries occurred because of the accident (circle all that apply):

- **Cuts**
- **Abrasions**
- **Bruises**
- **Bleeding from the mouth**
- **Bleeding of the nose**
- **Bleeding from the ears**
- **Other**: _____

8. Were you unconscious from the trauma? (circle one)
NO YES (how long? _____)

9. Did you have any memory loss from the trauma?
NO YES (how long was the memory loss? _____)

10. Immediately post-trauma, when and where were you treated (circle/answer all that applies):

- **When were you first evaluated**: Date: _____
- **Emergency room:** Name of facility: _____
- **Doctor's office** Name of Dr: _____
- **Other**: _____

11. After the trauma, what hurt? _____
_____

12. List ALL doctors who have treated you for this trauma and explain what they have done to date. E.G. Emergency Dr., Family Dr., Physical therapist, Chiropractor, Dentist, Oral Surgeon, Neurologist, Psychologist:

_____

_____

_____

13. Did you have x-rays of (circle all that apply):
Face Neck Skull Other: _____

14. Did you have a CT Scan (circle one)? **YES NO**

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For Doctor Notes Below:

15. Did you have an MRI (circle one)? **YES** **NO**

16. What other tests have been done?

_____

_____

17. Who do you feel is at fault for your trauma?

Explain: _____

_____

_____

18. Is your pain getting (circle one): **Better** **Worse** **Unchanged**

19. Do you have an attorney representing you (circle one):

- **NO**
- **YES**: Attorney's name: _____

I have completed the above questionnaire to the best of my knowledge and I personally have answered each question truthfully.

Signature: _____ **Date:** _____