Richard L.Alpert, D.D.S.

TRAUMA QUESTIONNAIRE

Leor Lindner, D.M.D.

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

I. Name _____ Date _____

Date of Trauma _____
Was your trauma from (circle one)
Auto Accident Fight Fall Other _____
How did the trauma happen? _____

II. Make of your car? _____ Your speed? _____
Make of other vehicle _____ Speed of other vehicle _____
Were you the (circle one) Driver Passenger front seat Passenger back seat
Other _____
Were you wearing a seat belt? Y N
Did you have a headrest? Y N
Shoulder strap? Y N Air bag? Y N
Did you strike the (circle all that apply)
Windshield Steering Wheel Dashboard
Other _____

III. During the trauma, did you strike your (circle all that apply)
Skull Chest Lower jaw Neck Face around nose
Other _____
Did you have whiplash? Y N
Which of the following did you have as a result of the accident?
Cut Abrasions Bruises Bleeding from mouth

IV. Were you knocked out? Y N How long? _____
What was your first memory after the trauma?

V. Immediately post-trauma, were you treated (circle all that apply)
Emergency room Doctor's office Other
Name of facility _____
When were you first seen for evaluation after the trauma? _____

VI. Did you have x-rays of the (circle all that apply)
Face Neck Skull Other _____
Did you have a CT scan? Y N
Did you have an MRI scan? Y N
What other tests did you have? _____

What did the emergency room doctor say was wrong and what treatment was prescribed? _____

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Name _____ Date _____

VII. Where did you first hurt? _____

When did you first notice: Headache _____
Neck pain _____
Jaw pain _____
Ear pain _____
Jaw joint noises _____

Before the trauma, which of these symptoms did you have (circle all that apply)

Headache Neck pain Ear pain Jaw pain
Jaw joint noises Pain with chewing Jaw locking

VIII. Before this trauma, had you ever noticed any other injury to the (circle all that apply)

Face Head Neck Other _____
What type? _____
Have you had other accidents that may have injured your head or neck? Y N
What type? _____
When? _____

IX. List all doctors who have treated you for this trauma and explain what they have done

Emergency physician

Dentist

Oral surgeon

Orthopedic surgeon

Neurologist

Neurosurgeon

Chiropractor

Psychologist/Psychiatrist

Physical Therapist

Other

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Name _____ Date _____

X. Who do you feel is at fault for your trauma? _____
Explain _____

XI. Is your pain getting (circle one)
Worse ? Better? Unchanged?
Over what time period _____
Do you expect your pain will get (circle one)
Worse? Better? Unchanged?

XII. Your attorney's name _____
Do you expect to file a lawsuit? Y N
When? _____

XIII. Have you ever sued or threatened to sue (circle all that apply)
Physician? Dentist? Hospital? Emergency Room?
Explain _____

XIV. I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing.

_____ _____
Signature Date

(Parent or Legal Guardian must also sign if the patient is under the age of 18.)