Mark A. Piper, M.D., D.M.D.

TRAUMA QUESTIONNAIRE

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? ______________

THE PIPER CLINIC

Mark A. Piper, M.D., D.M.D.

TRAUMA QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE

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 ______________________

____

____

THE PIPER CLINIC

Mark A. Piper, M.D., D.M.D.

TRAUMA QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE

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.)