Robert A. Lang, Jr., D.D.S

1859 Lake Road
Hamlin, New York 14464
Telephone 964-2000

TRAUMA QUESTIONNAIRE - PAGE 1

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE

I. NAME ______________________________ AGE _____

DATE OF TRAUMA: ______________________________

WAS YOUR TRAUMA FROM:
AUTO ACCIDENT? ________________ FIGHT? ____________________
OTHER? ______________________________

HOW DID THE TRAUMA HAPPEN? ______________________________
____
____
____

II. MAKE OF YOUR CAR? ____________ OTHER VEHICLE? ____________
SPEED OF YOUR CAR? ____________ OTHER VEHICLE? ____________

WERE YOU THE DRIVER? ______________________________
PASSENGER FRONT SEAT? ________ BACK SEAT? ______________
OTHER? ______________________________

WERE YOU WEARING A SEAT BELT? ______________________________
SHOULDER STRAP? ______________________________
DID YOU HAVE A HEADREST? ______ AIR BAG? ______________

WHAT DID YOU STRIKE? WINDSHIELD? ______________
STEERING WHEEL? ______________ DASHBOARD? ______________
OTHER? ______________________________

III. DURING THE TRAUMA DID YOU STRIKE YOUR:
SKULL? ________________ FACE AROUND NOSE? ______________
LOWER JAW? ________ NECK? ____________ CHEST? ____________

DID YOU HAVE WHIPLASH? ______________________________

DID YOU HAVE CUTS? ____________ ABRASIONS? ______________
BRUISES? ______________________________
BLEEDING FROM MOUTH? ______________________________
BLEEDING FROM NOSE? ______________________________
BLEEDING FROM EARS? ______________________________

IV. WERE YOU KNOCKED OUT:
SECONDS? ______________________ MINUTES? ______________
HOURS? ______________________ DAYS? ______________
WHAT IS YOUR FIRST MEMORY AFTER THE TRAUMA?
____
____

TRAUMA QUESTIONNAIRE - PAGE 2

YOUR NAME | DO NOT WRITE IN THIS SPACE

V. IMMEDIATELY AFTER THE TRAUMA, WERE YOU SEEN AND TREATED AT AN:

EMERGENCY ROOM? ______________________________
NAME

DOCTOR'S OFFICE? ______________________________
NAME

OTHER? ______________________________
NAME

WHEN WERE YOU FIRST SEEN FOR EVALUATION AFTER THE TRAUMA? ______________________________

VI. DID YOU HAVE X-RAYS OF THE SKULL? ______________
FACE? ____________ NECK? ____________ OTHER? ____________
DID YOU HAVE A CT SCAN? ______________________________
DID YOU HAVE AN MRI SCAN? ______________________________
OTHER TESTS? ______________________________

VII. WHERE DID YOU FIRST HURT? ______________________________
WHEN DID YOU FIRST NOTICE:
HEADACHE? ______________ NECK PAIN? ______________
JAW PAIN? ______________ EAR PAIN? ______________
JAW JOINT NOISES? ______________________________

BEFORE THE TRAUMA, HAD YOU EVER NOTICED:
HEADACHE? ______________ NECK PAIN? ______________
JAW PAIN? ______________ EAR PAIN? ______________
JAW JOINT NOISES? ______________________________
PAIN WITH CHEWING? ______________________________
JAW LOCKING? ______________________________

VIII. BEFORE THIS TRAUMA, HAD YOU EVER RECEIVED ANY OTHER INJURY: FACE? ______________
HEAD? ______________ NECK? ______________
WHAT TYPE? ______________________________

OTHER CAR ACCIDENTS? ______________ WHEN? ______________

IX. LIST ALL DOCTORS WHO HAVE TREATED YOU FOR THIS TRAUMA AND EXPLAIN WHAT THEY HAVE DONE:

EMERGENCY PHYSICIAN: ______________________________

____

YOUR NAME

FAMILY DOCTOR: ____________________

____

DENTIST: ____________________

____

ORAL SURGEON: ____________________

____

ORTHOPEDIC SURGEON: ____________________

____

NEUROLOGIST: ____________________

____

NEUROSURGEON ____________________

____

CHIROPRACTOR: ____________________

____

PSYCHOLOGIST/PSYCHIATRIST: ____________________

____

PHYSICAL THERAPIST: ____________________

____

OTHER: ____________________

____

OTHER: ____________________

____

OTHER: ____________________

____

DO NOT WRITE IN THIS SPACE

X. WHO DO YOU FEEL IS AT FAULT FOR YOUR TRAUMA ____________________

____

EXPLAIN: ____________________

____

XI. IS YOUR PAIN GETTING :
WORSE? ____________________ BETTER? ____________________
REMAINS UNCHANGED? ____________________
OVER WHAT TIME PERIOD? ____________________
DO YOU EXPECT THAT YOUR PAIN WILL GET:
WORSE? ____________________ BETTER? ____________________
REMAINS UNCHANGED? ____________________

XII. YOUR ATTORNEY'S NAME: ____________________

DO YOU EXPECT TO FILE A LAWSUIT? ____________________
AGAINST WHOM? ____________________
WHEN? ____________________

XIII. HAVE YOU PREVIOUSLY SUED OR THREATENED
TO SUE: PHYSICIAN? ____________________ ____________________DENT
EMERGENCY ROOM? ____________________ HOSPITAL? ____________________
PLEASE 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