First Name: __________________ Last Name: ____________________ MI: _____ Date: __________

What brings you to our office? [X] Auto accident

Description:

Date of accident? ______________

What was your position in the vehicle?
□ Driver
□ Middle Front Passenger
□ Front Passenger
□ Middle Rear Passenger
□ Right Rear Passenger

Time of the accident _________ □ AM □ PM

Location of accident______________

Your Vehicle speed ________________
Other vehicles speed?___________

What was the damage to the vehicle?
□ Mild □ Moderate
□ Extensive □ Totaled

How was the visibility on the road?
□ Poor □ Fair □ Good

And the weather was:
□ Clear □ Raining □ Windy
□ Foggy □ Wet

Who hit what?
□ You hit another vehicle
□ Another vehicle hit you
□ You hit another object
If an object, what was it? ___________________

What was the point of impact on our vehicle?
□ Right □ Right rear
□ Left □ Front end
□ Rear End □ Left front
□ Left rear □ Right front

Were you wearing a seatbelt?
□ Yes □ No

If yes, does the seatbelt have a shoulder harness/strap?
□ Yes □ No

Does your vehicle have an airbag?
□ Yes □ No
If yes did it deploy? □ Yes □ No

Did you strike anything inside the vehicle?
□ Yes □ No
If yes, what did you strike? _________________
And what part of your body hit it? ___________

Did you see the accident coming?
□ Yes □ No

Does your vehicle have headrests?
□ Yes □ No
If yes, positioned:
□ Even with top of head
□ Even with bottom of head
□ Middle of head

Where you braced for impact? □ Yes □ No

Where you dazed? □ Yes □ No

Did you Lose Consciousness?
If yes, for how long? _________

What direction was your head turned at the time of impact?
□ Right □ Left
□Straight ahead □ Other _____________

Was your head injured? □ Yes □ No

Other injuries? _____________________
Bruises_________________________________
Abrasions_______________________________
Lacerations_____________________________
Swelling________________________________
Bleeding________________________________
Fracture________________________________
Burns__________________________________

Immediately after the accident, did you experience:

□ Headache	□ Confusion	□ Depression	□ Irritability	□ Elbow pain
□ Low back pain	□ Nervousness	□ Ringing in ears	□ Constipation	□ Wrist pain
□ Neck pain	□ Diarrhea	□ Tension	□ Chest pain	□ Knee pain
□ Dizziness	□ Fainting	□ Foot pain	□ Pain behind eyes	□ Hip pain
□ Mid back pain	□ Fatigue	□ Hand pain	□ Shortness of breath	□ Ankle pain
□ Nausea	□ Loss of taste	□ Numbness	□ Sleeping problems	□ Other ____________
□ Neck stiffness	□ Loss of smell	□ Anxious	□ Shoulder pain	

Did you go to the hospital after the accident?

□ Yes □ No

If yes, which hospital? ________________

And how did you get there?

□ Drove self □ Ambulance

□ Someone else □ Police

Were any of the following tests performed?

□ X-rays □ MRI □ CT Scan □ Lab Work

Did you see another doctor before coming here?

□ Yes □ No

If yes please fill out the questions below:

1st Dr. Name: ______________________________

Test/ Procedures: __________________________

2nd Dr. Name: ______________________________

Test/ Procedures: __________________________

Do you feel that your condition is improving?

□Improving □Staying the same □Getting worse

Occupation:______________________________

Have you lost time from work? □ Yes □ No

If yes, for how long? ________________

Can you perform physical work activities?

□ Yes □ No

If no, why? □Pain □Weakness □Stress

Job Duties: ______________________________

Financial burden for patient and family?

□ Yes □ No

If yes, Explain______________________________

Have you been in an accident before?

□ Yes □ No

If yes, when? (year)__________

Dr. who treated: ________________________

Details: ______________________________

Any residual problems? __________________

Explain: ______________________________

Have you have more than one accident in the past?

□ Yes □ No

If yes, when? (year)__________

Dr. who treated: ________________________

Details: ______________________________

Any residual problems? __________________

Explain: ______________________________

Activities of Daily Living

Please select all activities which you are currently experiencing problems:

□ Seeing	□ Tasting	□ Smelling	□ Eating
□ Hearing	□ Bathing	□ Grooming	□ Dressing
□ Reading	□Typing	□Writing	□Grasping
□ Holding	□ Pinching	□ Standing	□ Leaning
□ Walking	□ Stooping	□ Squatting	□ Climbing
□ Kneeling	□ Bending	□ Twisting	□ Carrying
□ Lifting	□ Pushing	□ Pulling	□ Reaching

□ Sitting □ Driving □ Riding in a car □ Air Travel

□ Sports □ Exercising □ Loss of Sexual Drive

□ Reclining □ Restful sleeping

□ Insomnia □ Using the toilet

□ Loss of concentration □ Nervous □ Irritable

□ Changes in personality □ Tactile feeling

Additional activities of Daily living ______________

Can you go to sleep without problems?

□ Yes □ No

Do you awaken because of pain? □ Yes □ No

Did you have sleeping problems before the accident? □ Yes □ No

Are you pregnant? □ Yes □ No □ I'm not sure

What was the date of your last period? __________

Complaint #1 ______________________________

Grade: *(1-10 with 10 being the highest)* __________

Came on: □ gradual □ immediate

Is it getting: □ better □ worse □ same

Intensity: □ minimal □ slight □ mild
□ mild-moderate □Moderate
□ moderate-severe □severe

Frequency: □Intermittent □ Occasional
□ Frequent □ Constant

Describe feeling: □ Dull □ Sharp □ Aching
□ Shooting □ Spasm □ Throbbing □ Burning
□ Numbing □ Tingling □ Other: ____________

Location: □ Both □ Left □ Right

Actions effecting this complaint:

In the A.M. □Brings on □Aggravates □Relieves
Bending back □Brings on □Aggravates □Relieves
Twisting left □Brings on □Aggravates □Relieves
Sneezing □Brings on □Aggravates □Relieves
Lifting □Brings on □Aggravates □Relieves
Cold □Brings on □Aggravates □Relieves
Medications □Brings on □Aggravates □Relieves
In the P.M. □Brings on □Aggravates □Relieves
Bending left □Brings on □Aggravates □Relieves
Twisting right □Brings on □Aggravates □Relieves
Straining □Brings on □Aggravates □Relieves
Sitting □Brings on □Aggravates □Relieves
Rest □Brings on □Aggravates □Relieves
Bending front □Brings on □Aggravates □Relieves
Bending right □Brings on □Aggravates □Relieves
Coughing □Brings on □Aggravates □Relieves
Standing □Brings on □Aggravates □Relieves
Heat □Brings on □Aggravates □Relieves
Lying down □Brings on □Aggravates □Relieves
Other ___________________ **Effect** ____________

Radiates to: □Head □Neck □Shoulder
□Arm □Hand □Hip □Leg
□Foot □Other____________________

Complaint #2 ______________________________

Grade: *(1-10 with 10 being the highest)* __________

Came on: □ Gradual □ Immediate

Is it getting: □ Better □ Worse □ Same

Intensity: □ Minimal □ Slight □ Mild
□ Mild-Moderate □Moderate
□ Moderate-Severe □Severe

Frequency: □Intermittent □ Occasional
□ Frequent □ Constant

Describe feeling: □ Dull □ Sharp □ Aching
□ Shooting □ Spasm □ Throbbing □ Burning
□ Numbing □ Tingling □ Other: ____________

Location: □ Both □ Left □ Right

Actions effecting this complaint:

In the A.M. □Brings on □Aggravates □Relieves
Bending back □Brings on □Aggravates □Relieves
Twisting left □Brings on □Aggravates □Relieves
Sneezing □Brings on □Aggravates □Relieves
Lifting □Brings on □Aggravates □Relieves
Cold □Brings on □Aggravates □Relieves
Medications □Brings on □Aggravates □Relieves
In the P.M. □Brings on □Aggravates □Relieves
Bending left □Brings on □Aggravates □Relieves
Twisting right □Brings on □Aggravates □Relieves
Straining □Brings on □Aggravates □Relieves
Sitting □Brings on □Aggravates □Relieves
Rest □Brings on □Aggravates □Relieves
Bending front □Brings on □Aggravates □Relieves
Bending right □Brings on □Aggravates □Relieves
Coughing □Brings on □Aggravates □Relieves
Standing □Brings on □Aggravates □Relieves
Heat □Brings on □Aggravates □Relieves
Lying down □Brings on □Aggravates □Relieves
Other ___________________ **Effect** ____________

Radiates to: □Head □Neck □Shoulder
□Arm □Hand □Hip □Leg
□Foot □Other____________________

Complaint #3 ______________________________

Grade: *(1-10 with 10 being the highest)* __________

Came on: □ gradual □ immediate

Is it getting: □ better □ worse □ same

Intensity: □ minimal □ slight □ mild
□ mild-moderate □Moderate
□ moderate-severe □severe

Frequency: □Intermittent □ Occasional
□ Frequent □ Constant

Describe feeling: □ Dull □ Sharp □ Aching
□ Shooting □ Spasm □ Throbbing □ Burning
□ Numbing □ Tingling □ Other: ____________

Location: □ Both □ Left □ Right

Actions effecting this complaint:

In the A.M. □Brings on □Aggravates □Relieves
Bending back □Brings on □Aggravates □Relieves
Twisting left □Brings on □Aggravates □Relieves
Sneezing □Brings on □Aggravates □Relieves
Lifting □Brings on □Aggravates □Relieves
Cold □Brings on □Aggravates □Relieves
Medications □Brings on □Aggravates □Relieves
In the P.M. □Brings on □Aggravates □Relieves
Bending left □Brings on □Aggravates □Relieves
Twisting right□Brings on □Aggravates □Relieves
Straining □Brings on □Aggravates □Relieves
Sitting □Brings on □Aggravates □Relieves
Rest □Brings on □Aggravates □Relieves
Bending front□Brings on □Aggravates □Relieves
Bending right□Brings on □Aggravates □Relieves
Coughing □Brings on □Aggravates □Relieves
Standing □Brings on □Aggravates □Relieves
Heat □Brings on □Aggravates □Relieves
Lying down □Brings on □Aggravates □Relieves
Other ___________________ **Effect** ___________

Radiates to: □Head □Neck □Shoulder
□Arm □Hand □Hip □Leg
□Foot □Other____________________

Complaint #4 ______________________________

Grade: *(1-10 with 10 being the highest)* _________

Came on: □ Gradual □ Immediate

Is it getting: □ Better □ Worse □ Same

Intensity: □ Minimal □ Slight □ Mild
□ Mild-Moderate □Moderate
□ Moderate-Severe □Severe

Frequency: □Intermittent □ Occasional
□ Frequent □ Constant

Describe feeling: □ Dull □ Sharp □ Aching
□ Shooting □ Spasm □ Throbbing □ Burning
□ Numbing □ Tingling □ Other: ____________

Location: □ Both □ Left □ Right

Actions effecting this complaint:

In the A.M. □Brings on □Aggravates □Relieves
Bending back □Brings on □Aggravates □Relieves
Twisting left □Brings on □Aggravates □Relieves
Sneezing □Brings on □Aggravates □Relieves
Lifting □Brings on □Aggravates □Relieves
Cold □Brings on □Aggravates □Relieves
Medications □Brings on □Aggravates □Relieves
In the P.M. □Brings on □Aggravates □Relieves
Bending left □Brings on □Aggravates □Relieves
Twisting right□Brings on □Aggravates □Relieves
Straining □Brings on □Aggravates □Relieves
Sitting □Brings on □Aggravates □Relieves
Rest □Brings on □Aggravates □Relieves
Bending front□Brings on □Aggravates □Relieves
Bending right□Brings on □Aggravates □Relieves
Coughing □Brings on □Aggravates □Relieves
Standing □Brings on □Aggravates □Relieves
Heat □Brings on □Aggravates □Relieves
Lying down □Brings on □Aggravates □Relieves
Other ___________________ **Effect** ___________

Radiates to: □Head □Neck □Shoulder
□Arm □Hand □Hip □Leg
□Foot □Other____________________

Complaint #5 ______________________________

Grade: *(1-10 with 10 being the highest)* __________

Came on: □ gradual □ immediate

Is it getting: □ better □ worse □ same

Intensity: □ minimal □ slight □ mild
□ mild-moderate □Moderate
□ moderate-severe □severe

Frequency: □Intermittent □ Occasional
□ Frequent □ Constant

Describe feeling: □ Dull □ Sharp □ Aching
□ Shooting □ Spasm □ Throbbing □ Burning
□ Numbing □ Tingling □ Other: ____________

Location: □ Both □ Left □ Right

Actions effecting this complaint:

In the A.M. □Brings on □Aggravates □Relieves
Bending back □Brings on □Aggravates □Relieves
Twisting left □Brings on □Aggravates □Relieves
Sneezing □Brings on □Aggravates □Relieves
Lifting □Brings on □Aggravates □Relieves
Cold □Brings on □Aggravates □Relieves
Medications □Brings on □Aggravates □Relieves
In the P.M. □Brings on □Aggravates □Relieves
Bending left □Brings on □Aggravates □Relieves
Twisting right □Brings on □Aggravates □Relieves
Straining □Brings on □Aggravates □Relieves
Sitting □Brings on □Aggravates □Relieves
Rest □Brings on □Aggravates □Relieves
Bending front □Brings on □Aggravates □Relieves
Bending right □Brings on □Aggravates □Relieves
Coughing □Brings on □Aggravates □Relieves
Standing □Brings on □Aggravates □Relieves
Heat □Brings on □Aggravates □Relieves
Lying down □Brings on □Aggravates □Relieves
Other ___________________ **Effect** ___________

Radiates to: □Head □Neck □Shoulder
□Arm □Hand □Hip □Leg
□Foot □Other____________________

Complaint #6 ______________________________

Grade: *(1-10 with 10 being the highest)* __________

Came on: □ Gradual □ Immediate

Is it getting: □ Better □ Worse □ Same

Intensity: □ Minimal □ Slight □ Mild
□ Mild-Moderate □Moderate
□ Moderate-Severe □Severe

Frequency: □Intermittent □ Occasional
□ Frequent □ Constant

Describe feeling: □ Dull □ Sharp □ Aching
□ Shooting □ Spasm □ Throbbing □ Burning
□ Numbing □ Tingling □ Other: ____________

Location: □ Both □ Left □ Right

Actions effecting this complaint:

In the A.M. □Brings on □Aggravates □Relieves
Bending back □Brings on □Aggravates □Relieves
Twisting left □Brings on □Aggravates □Relieves
Sneezing □Brings on □Aggravates □Relieves
Lifting □Brings on □Aggravates □Relieves
Cold □Brings on □Aggravates □Relieves
Medications □Brings on □Aggravates □Relieves
In the P.M. □Brings on □Aggravates □Relieves
Bending left □Brings on □Aggravates □Relieves
Twisting right □Brings on □Aggravates □Relieves
Straining □Brings on □Aggravates □Relieves
Sitting □Brings on □Aggravates □Relieves
Rest □Brings on □Aggravates □Relieves
Bending front □Brings on □Aggravates □Relieves
Bending right □Brings on □Aggravates □Relieves
Coughing □Brings on □Aggravates □Relieves
Standing □Brings on □Aggravates □Relieves
Heat □Brings on □Aggravates □Relieves
Lying down □Brings on □Aggravates □Relieves
Other ___________________ **Effect** ___________

Radiates to: □Head □Neck □Shoulder
□Arm □Hand □Hip □Leg
□Foot □Other____________________

Surgical History *Please select all surgeries that you have had in the past.*

☐ None
☐ Gastric Bypass
☐ Hip Joint Replacement
☐ Knee surgery
☐ Prostate Surgery
☐ Cosmetic Breast Surgery
☐ Heart Bypass Surgery
☐ Hysterectomy
☐ Rotator Cuff Surgery
☐ C-Section
☐ Heart Surgery
☐ Kidney Surgery
☐ Appendectomy
☐ Knee Arthroscopy
☐ Lumbar spine surgery
☐ TMJ Surgery
☐ Bone Fracture Repair
☐ Cervical spine Surgery
☐ Gallbladder Removal
☐ Hernia Repair
☐ Mastectomy
☐ Other ______________
____

Past Medical History *Please select all conditions that you have had **PRIOR** to the accident:*

☐None
☐Bladder infection
☐Cancer
☐Colitis
☐Dermatitis, Eczema/Rash
☐General fatigue
☐Jaw pain
☐ Loss of bladder control
☐Muscular in coordination
☐ Pain in upper arm or elbow
☐Scoliosis
☐Anxiety
☐Blood disorder
☐Cardiovascular disease/heart attack
☐Constipation
☐Diabetes
☐Epilepsy
☐Heartburn/Indigestion
☐Kidney disorders
☐Low back pain
☐Neck pain
☐Pain in upper Leg and hip
☐ Prostate problems
☐Shoulder pain
☐Tuberculosis
☐Abdominal pain
☐Aortic aneurysm
☐Convulsions
☐Hand pain
☐Hepatitis
☐Lung Disease
☐Painful/ excessive urination
☐Stroke
☐Abnormal Weight gain/loss
☐Arthritis
☐Chronic cough
☐COPD
☐ Dizziness
☐ Fainting
☐Headache
☐ High Blood Pressure
☐Irregular menstrual flow
☐ Liver/Gallbladder problems
☐Mental Disease
☐Pain in ankle or foot
☐Renal Disease
☐Swelling/stiffness of joints
☐Ulcer
☐Asthma
☐Bronchitis
☐Chronic sinusitis
☐Depression
☐High cholesterol/ triglycerides
☐Loss of appetite
☐Mid back pain
☐Pain in lower leg or knee
☐Pneumonia
☐Rheumatoid arthritis
☐Thyroid disease
☐Visual disturbances
☐ Other ______________
____

Family History *Please select all conditions that run in your family:*

☐ None
☐Anorexia
☐Cancer
☐Colitis
☐ Dermatitis, Eczema/Rash
☐ Endometriosis
☐Scoliosis
☐Anxiety
☐Blood disorder
☐Cardiovascular disease/heart attack
☐Constipation
☐Diabetes
☐Epilepsy
☐Gout
☐Heartburn/Indigestion
☐Kidney disorders
☐Low back pain
☐Neck pain
☐Prostate problems
☐Abdominal pain
☐Lung Disease
☐Osteoarthritis
☐Painful urination
☐Rapid heart beat
☐Stroke
☐Abnormal Weight gain/loss
☐Chronic cough
☐COPD
☐ Dizziness
☐ Fainting
☐ Headache
☐ High Blood Pressure
☐Liver/Gallbladder
☐Mental Disease
☐Ulcer
☐Other ______________
____

Medications *Please select all medications that you are currently taking:*

☐ None
☐ Daily Vitamins
☐ Muscle relaxers
☐ Diabetes Medication
☐ Pain Medication
☐ Anti-inflammatories
☐ Blood Pressure Medication
☐ Other ________________________
☐ Over the counter______________
____

Allergies *Please select all items that you are allergic to:*

☐ None
☐ Anaphylactic type Allergies
☐ Medication Allergies
☐ Airborne Allergies
☐ Chemical Allergies
☐ Food Allergies
☐ Seasonal Allergies

Social History *Please answer the following questions:*

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐Separated

Do you have children? ☐ **Yes** ☐ No If yes, how many?_________

Do you use: ☐**Tobacco** ☐**Alcohol** ☐ Excessive use of Coffee