

Date _____

Patient Name _____ Patient Account Number _____

▶ **INJURY DATE AND LOCATION**

Date of Injury: _____ City/Town: _____

Intersection: _____ Route/Highway: _____

▶ **YOUR POSITION IN AUTOMOBILE ACCIDENT**

Were you: Driver Front seat passenger Backseat passenger Other _____

▶ **YOUR VEHICLE**

Year, Make, Model: _____

Your estimated speed at the moment of the accident _____ mph. Stopped Slowing Accelerating

Point of impact to your vehicle: Front Back Left Right Other: _____

Was the impact to your vehicle? Light Moderate Heavy Damage estimate \$ _____

▶ **AUTOMOBILE ACCIDENT DESCRIPTION**

Please describe how the accident happened: _____

Did accident happen while you were on job? Yes No

Name of person driving the vehicle (if other than patient) _____

▶ **OTHER VEHICLE**

Year, Make, Model: _____

Their estimated speed at the moment of the accident _____ mph. Stopped Slowing Accelerating

Were there any other vehicles involved? Yes No

If yes, please describe: _____

▶ **SEAT BELTS AND AIRBAGS**

Were you wearing a seatbelt? Yes No

Did your air bag deploy? Yes No

Did your seat break or bend? Yes No

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▶ **AT THE TIME OF IMPACT**

Which way was your body pointed at the time of impact? Straight Right Left

Which way was your head pointed at the time of impact? Straight Right Left

Were you leaning forward at the time of impact? Yes No

Did you brace before impact or were you relaxed? Relaxed Braced - **Against What?** _____

Did any body part of yours strike anything within the vehicle at the time of impact? Yes No

If "YES", specify what part of your body struck what: (i.e. head, chest, left shoulder, right knee, etc.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Steering Wheel _____ | <input type="checkbox"/> Windshield _____ | <input type="checkbox"/> Dashboard _____ |
| <input type="checkbox"/> Left Side Door _____ | <input type="checkbox"/> Right Side Door _____ | <input type="checkbox"/> Roof _____ |
| <input type="checkbox"/> Left Window _____ | <input type="checkbox"/> Right Window _____ | <input type="checkbox"/> Other _____ |

Immediately following the accident, how did you feel? (Circle all that apply)

Dizzy Dazed Weak Upset Disoriented Nervous Nauseous Other: _____

Did you lose consciousness? Yes No For how long? _____

Were you able to get out of the vehicle on your own? Yes No

▶ **TREATMENT AT THE SCENE OF THE ACCIDENT**

Did an ambulance come to the scene of the accident? Yes No

If yes, did you receive treatment at the scene of the accident? Yes No

What kind of treatment? _____

▶ **TREATMENT AT THE HOSPITAL**

Were you transported to the hospital? Yes No If yes, which hospital? _____

How did you get there? Ambulance Police Private Transportation

Were you admitted? Yes No If yes, how long? _____

What treatment was given at the hospital? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Stitches |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Bandaged |
| <input type="checkbox"/> Cervical/Neck Collar | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Instructed Regarding Concussion | <input type="checkbox"/> Instructed Regarding Sprains & Strains |
| <input type="checkbox"/> Instructed to call an Orthopedist/Neurologist | <input type="checkbox"/> Instructed to call a Private Physician |
| <input type="checkbox"/> CAT Scan/MRI | <input type="checkbox"/> Other: _____ |

▶ **OTHER DOCTORS**

Have you seen any other Doctors for your injuries prior to coming to our office? Yes No

If yes, who and what did they do for you? _____

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▶ CHIEF COMPLAINTS

Please "X" any complaints that you have been experiencing since your accident. Do not fill in the area "For Doctor Use Only".

FOR DOCTOR USE ONLY

"X"	COMPLAINTS	LOCATION				ONSET	VAS	DESCRIPTION / REMARKS
	NECK PAIN	LF	RT	MID	BILAT			
	JAW PAIN	LF	RT	BILAT				
	UPPER BACK PAIN	LF	RT	MID	BILAT			
	MID BACK PAIN	LF	RT	MID	BILAT			
	SHOULDER PAIN	LF	RT	BILAT				
	ARM / WRIST PAIN	LF	RT	BILAT				
	HAND / FINGER PAIN	LF	RT	BILAT				
	LOW BACK PAIN	LF	RT	MID	BILAT			
	HIP PAIN	LF	RT	BILAT				
	LEG / KNEE PAIN	LF	RT	BILAT				
	ANKLE / FOOT / TOES	LF	RT	BILAT				
	NUMBNESS / TINGLING	LF	RT	BILAT	↑ ↓			
	RADIATING PAIN	LF	RT	BILAT	↑ ↓			
	HEADACHES	LF	RT	FRONT	OCC			Duration: _____ Freq: _____

▶ OTHER COMPLAINTS

Please "X" any complaints that you have been experiencing since your accident.

FOR DOCTOR USE ONLY

	Anxiety	Doctors Notes
	When I am traveling in a vehicle	
	When someone else is driving and I do not feel in control	
	When another vehicle is following too close to me	
	When I get near the scene of where the accident occurred	
	Other:	
	Difficulty Sleeping	
	Because of pain and discomfort	
	Nightmares about the accident	
	Other:	
	Please indicate the number of hours you are able to sleep at night:	
	Depression	
	What do you feel is causing you to be depressed?	
	Memory Loss	
	Concentration	
	Other	

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DUTIES UNDER DURESS

Are there day to day activities which are painful or difficult for you to perform as a result of your injuries?

Check all those that apply & write in the reason why you have difficulty performing the activity.

FOR DOCTOR USE

<input type="checkbox"/> Work	Reason for the difficulty	Duration

<input type="checkbox"/> Studies/School	Reason for the difficulty	Duration

Domestic Duties	Reason for the difficulty	Duration
<input type="checkbox"/> Vacuuming		
<input type="checkbox"/> Taking care of children		
<input type="checkbox"/> Dishes/Dusting/Laundry		
<input type="checkbox"/> Preparing meals		
<input type="checkbox"/> Personal Care/bathing, dressing		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

Household Duties	Reason for the difficulty	Duration
<input type="checkbox"/> Mowing/Yard work		
<input type="checkbox"/> Transporting family		
<input type="checkbox"/> Shopping		
<input type="checkbox"/> Taking out trash		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

LOSS OF ENJOYMENT

Are there areas of your life which you normally would be enjoying but are currently not enjoying, as a result of your injuries?

Hobbies/Recreation	Reason for the difficulty	Duration
<input type="checkbox"/> Jogging		
<input type="checkbox"/> Dancing		
<input type="checkbox"/> Shopping		
<input type="checkbox"/> Traveling		
<input type="checkbox"/> Working Out		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

Sports	Reason for the difficulty	Duration
<input type="checkbox"/> Social		
<input type="checkbox"/> Competitive		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

Sexual Relations	Reason for the difficulty	Duration
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		