

AUTOMOBILE ACCIDENT HISTORY

Patient Name _____ Todays Date _____ Date of Injury _____

Was the accident on the job? Yes No

Where were you seated in the vehicle? _____

Name of person driving the vehicle _____

Your Vehicle (year, make, model) _____

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

If stopped, was your foot on the brake Yes No

Other Vehicle (year, make, model) _____

Estimated speed of the other vehicle at moment of impact _____ Stopped Slowing Accelerating

Road conditions at the time of the accident:

Dry Damp Wet Snow Ice

Time of day:

Daylight Dawn Dusk Dark

Head restraints, Seat backs:

How far is the top of the headrest or seatback from the back of your head? _____ inches

If adjustable, was the position of the headrest altered by the accident? Yes No

Was the seat back adjustment altered by the accident? Yes No

Was the seat broken Yes No

Seat belts and Air bags:

Were you wearing a seatbelt? Yes No Don't know

What type? Lap seat belt Shoulder seat belt Shoulder-lap seat belt

Did your air bag deploy? Yes No

If yes, were you struck? Yes No Where? _____

Head and Body position:

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

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

Patient signature

Date

ACCIDENT DIAGRAM

[Empty box for accident diagram]

In the space below, please describe, to the best of your knowledge, what happened during this accident

[Empty space for accident description]

DURING THE CRASH:

Position of hands: One on wheel Two on wheel N/A

Did you strike any parts of the vehicle? Yes No

If yes, please describe _____

Did vehicle strike any objects after the crash? Yes No

If yes, please describe _____

Were you aware or surprised of the approaching collision? Aware Surprised

Were you wearing a hat or glasses? Yes No

If yes, were they still on after the crash Yes No

Did you lose consciousness (black out) upon impact? Yes How long? _____ No

Did you experience a flash of light or explosion in your head? Yes No

AFTER THE CRASH

Did you become : Confused Disoriented Light headed Dizzy

Nauseated Blurred vision Ring/Buzz in ears

If you still have any of those symptoms, which ones: _____

Are you currently suffering from any of the following:

Restlessness Irritable Difficulty concentrating Difficulty with memory

Sleeplessness Forgetful Reduced tolerance to heat Reduced tolerance to alcohol

Did the police come to the accident scene? Yes No Is there a report? Yes No

Patient signature

Date

HOSPITAL

Did you go to the hospital? Yes No

How did you get to the hospital? _____

Name and city of hospital _____

Name of emergency room doctor _____

What parts of body were x-rayed at the hospital? _____

How long did you stay in the hospital? _____

What did the hospital do for your injuries? Cervical collar Ice pack

Medications _____ Follow up instructions _____

ORIGINAL COMPLAINTS- If the accident is more than one month old

If accident was within the last month, skip this section and go to the next page.

1) _____

Date when symptom first appeared _____

How often did you experience the symptoms?

- Constant 100% Frequent 75%
- Intermittent 50% Occasional 25% Rare 10%

What made symptom increase? _____

What gave relief of symptom? _____

Type of pain:

- Sharp Dull Aching Burn
- Throb Numb Other _____

Where did the pain radiate to? _____

Rate the symptoms from 1 to 10 (10 = worst) _____

2) _____

Date when symptom first appeared _____

How often did you experience the symptoms?

- Constant 100% Frequent 75%
- Intermittent 50% Occasional 25% Rare 10%

What made symptom increase? _____

What gave relief of symptom? _____

Type of pain:

- Sharp Dull Aching Burn
- Throb Numb Other _____

Where did the pain radiate to? _____

Rate the symptoms from 1 to 10 (10 = worst) _____

3) _____

Date when symptom first appeared _____

How often did you experience the symptoms?

- Constant 100% Frequent 75%
- Intermittent 50% Occasional 25% Rare 10%

What made symptom increase? _____

What gave relief of symptom? _____

Type of pain:

- Sharp Dull Aching Burn
- Throb Numb Other _____

Where did the pain radiate to? _____

Rate the symptoms from 1 to 10 (10 = worst) _____

4) _____

Date when symptom first appeared _____

How often did you experience the symptoms?

- Constant 100% Frequent 75%
- Intermittent 50% Occasional 25% Rare 10%

What made symptom increase? _____

What gave relief of symptom? _____

Type of pain:

- Sharp Dull Aching Burn
- Throb Numb Other _____

Where did the pain radiate to? _____

Rate the symptoms from 1 to 10 (10 = worst) _____

Patient signature

Date

CURRENT COMPLAINTS -

Please list, in detail, all current symptoms / complaints in order of severity

1) _____

Date when symptom first appeared _____

How often do you experience the symptoms?

- Constant 76-100%
- Frequent 51-75%
- Intermittent 26-50%
- Occasional 11-25%
- Rare 10%

Describe any recently related accident or fall _____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

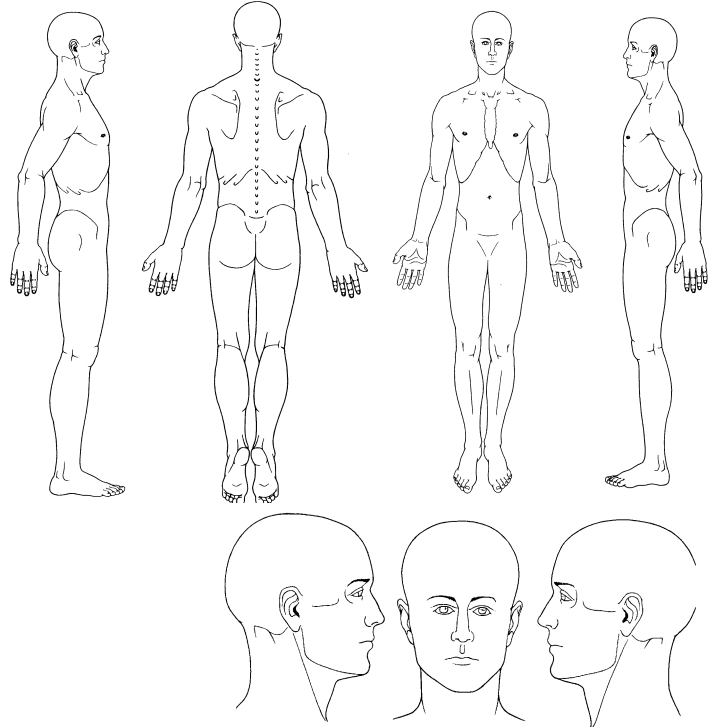
- Sharp
- Dull
- Aching
- Burn
- Throb
- Numb
- Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 _____ 5 _____ 10

Please mark your areas of pain on the figures below



2) _____

Date when symptom first appeared _____

How often do you experience the symptoms?

- Constant 76-100%
- Frequent 51-75%
- Intermittent 26-50%
- Occasional 11-25%
- Rare 10%

Describe any recently related accident or fall _____

What makes symptom increase? _____

What gives relief of symptom? _____

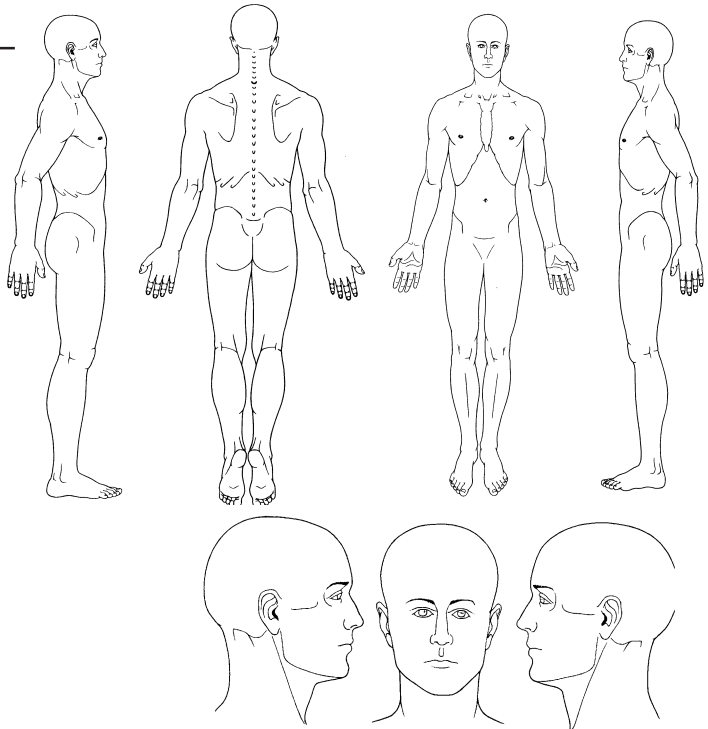
Type of pain:

- Sharp
- Dull
- Aching
- Burn
- Throb
- Numb
- Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 _____ 5 _____ 10



Patient signature

Date

CURRENT COMPLAINTS Continued

3) _____

Date when symptom first appeared _____

How often do you experience the symptoms?

- Constant 76-100% Frequent 51-75%
 Intermittent 26-50% Occasional 11-25% Rare 10%

Describe any recently related accident or fall _____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

- Sharp Dull Aching Burn
 Throb Numb Other _____

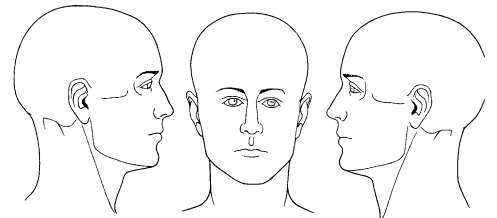
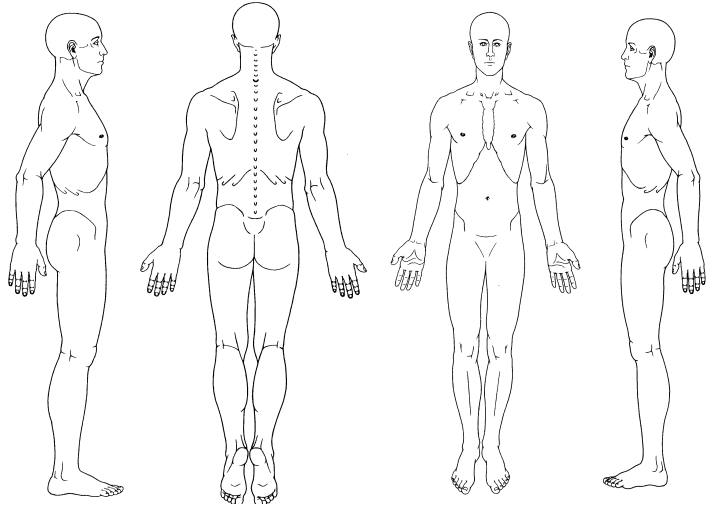
Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 _____ 5 _____ 10

Patient Name

Please mark your areas of pain on the figures below



4) _____

Date when symptom first appeared _____

How often do you experience the symptoms?

- Constant 76-100% Frequent 51-75%
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Describe any recently related accident or fall _____

What makes symptom increase? _____

What gives relief of symptom? _____

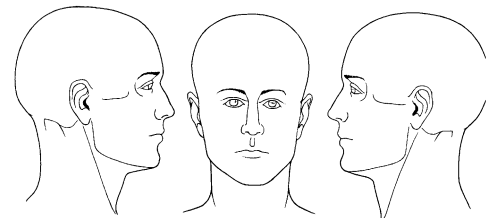
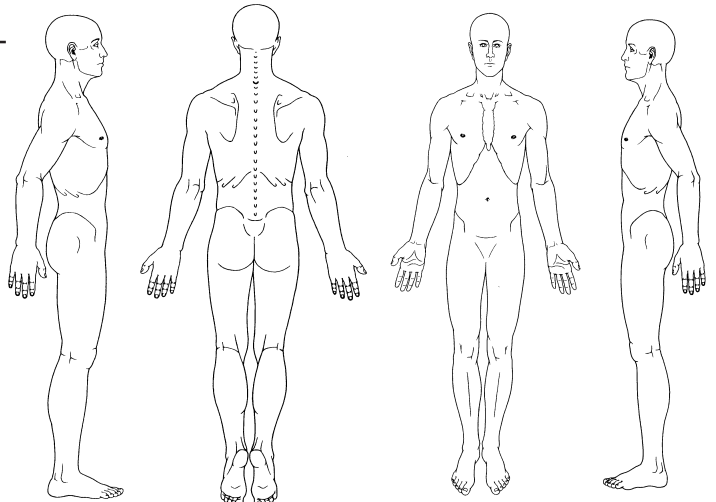
Type of pain:

- Sharp Dull Aching Burn
 Throb Numb Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 _____ 5 _____ 10



Patient Signature

Date

PLEASE LIST ALL PREVIOUS TREATMENTS FOR CONDITIONS RELATED TO THIS ACCIDENT

1) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

2) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

3) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

4) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

5) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

6) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

7) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

Patient Signature

Date

PAST HEALTH HISTORY

PLEASE LIST ALL SUGERGIES YOU HAVE HAD

Patient Name _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

PLEASE LIST ALL PREVIOUS FRACTURES AND DISLOCATIONS

What _____ When _____

What _____ When _____

Remarks _____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

PLEASE LIST ANY PRIOR HISTORY OF CURRENT COMPLAINTS

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

PLEASE LIST ALL PRIOR ACCIDENTS, ASSOCIATED COMPLAINT AND TREATMENTS

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

OCCUPATIONAL INFORMATION

Job Involves:

Sitting Standing How long _____ Desk Counter Other _____

Lifting How much weight _____ Bending Stooping Twisting Turning

Type of shoes High heels Boots Arch supports Other _____

How long do you speak on the telephone each day _____ Traditional telephone receiver Headset

Physical activity at work Sedentary Light manual labor Manual labor Heavy manual labor

Do any of your work activities aggravate your present main complaints? Please describe _____

Patient Signature

Date

HEALTH HABITS: How much per day or week?

Patient Name _____

Tea, coffee _____ Liquor _____ Tobacco _____ Sugar, candy, ice cream _____

Exercise: 1) Type _____ Frequency _____ 2) Type _____ Frequency _____

3) Type _____ Frequency _____ 4) Type _____ Frequency _____

Sleep: Hours per night _____ Type of mattress _____ Naps _____

Do you sleep on your Back Side Stomach

Please describe your sleep _____

Special diets _____

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD

- HIV Positive
- Anemia
- Appendicitis
- Arteriosclerosis
- Arthritis
- Cancer
- Tuberculosis
- Goiter
- Gout
- Heart Disease
- Herpes
- Influenza
- Lumbago
- Small Pox
- Tuberculosis
- Typhoid Fever
- Ulcers
- Venereal Infection
- Whooping Cough
- Cold Sores
- Allergies
- Diabetes
- Diphtheria
- Eczema
- Emphysema
- Epilepsy
- Hypersensitivity
- Asthma
- Malaria
- Measles
- Miscarriage
- Multiple Sclerosis
- Mumps
- Pleurisy
- Chicken Pox
- Pneumonia
- Polio
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Other _____

DISABILITY

Do you have a permanent disability rating? _____ Location _____ Date received _____

Rating Percentage _____

X-RAY CONFIRMATION- FEMALES

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

Signed _____

Date _____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge

Patient Signature

Date

DOCTORS NOTES:

ACTIONS TAKEN ON THIS VISIT

- Examination/TX _____
- X-rays _____
- Disability _____
- Work restriction _____
- Supplies _____
- Tests/Referrals _____