

Patient Basic Information

Personal Information:

Last Name:		First Name:		Middle Initial:
Address:		City, State, Zip:		
Phone Home:	Phone Work:		Social Security No.:	
Date of Birth:		Date of Injury/Onset:		
Dominant Hand:		<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
Insurance Information: Policy Holder (if different than patient):			Policy No.:	

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. During and after accident details

Enter the details of your condition during and after the accident/onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, don't answer those questions.

1. Your vehicle type

Car Station Wagon
 Van Pickup Truck
 Bus Large Truck
 Other _____

2. Your position in vehicle

Driver Front passenger
 Left Rear passenger
 Right Rear passenger
 Other _____

3. What was your vehicle doing at the time of the accident?

Stopped at intersection Stopped in traffic Stopped at light
 Making a right turn Making a left turn Parking
 Proceeding along Slowing down Accelerating
 Other _____

4. Time/Speed/Damage

Time of accident _____
 Your vehicle's speed: _____ mph
 Their vehicle's speed: _____ mph
 Damage to your vehicle
 Mild Moderate
 Totaled

5. Details of Accident

Visibility at time of accident
 Poor Fair Good
 Who hit who/what?
 You hit other vehicle
 Other vehicle hit you
 You hit...(object)

6. Road conditions

Road conditions at time of accident
 Icy Wet Sandy Dark Clean and dry
 Point of impact
 Head-On Left Front Right Front
 Read-End Left Rear Right Rear

7. Body Position, etc.

Did you see the accident coming? Yes No
 Were you braced for the impact? Yes No
 Did you have a seat belt on? Yes No
 Did you have a shoulder harness on? Yes No

8. Does your vehicle have headrests?

Yes No
 What was the position of your headrest at the time of the impact?
 Even with top of head Even with bottom of head
 Middle of neck
 What was the direction of your head at the time of the impact? harness
 Facing straight forward Turned to the right
 Turned to the left

9. During the accident:

Did your body strike the inside of your vehicle? Yes No
 If yes, describe: _____
 Did you lose consciousness during the injury? Yes No
 If yes, for how long? _____
 Your vehicle's estimated damage? _____
 Damage to your vehicle: Mild Moderate Totaled
 Did police show up at the scene? Yes No
 Was an accident report filled out? Yes No

10. After the accident:

Check off your symptoms right after and a few days following:
 Headache Dizziness Mid back pain Cold hands
 Neck pain Nausea Low back pain Cold feet
 Neck stiffness Confusion Nervousness Diarrhea
 Fainting Fatigue Loss of taste Depression
 Ringing in ears Tension Toe numbness Anxious
 Loss of smell Irritability Constipation Chest Pain
 Pain behind eyes Shortness of breath Sleeping problems
 Others: _____

11. Emergency Room?

Where did you go after the accident?
 Home Work Hospital ER Private Doctor
 How did you get there?
 Drove self Somebody else Ambulance Police
 X-rays done: Yes No Was lab work done? Yes No
 Body parts X-rayed? _____
 What lab work? _____
 The X-rays revealed: _____
 Treatments: Cervical Collar Ice Other _____
 Medications: _____
 Follow-up instructions: _____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
 1. Dr. _____ First visit date: ____/____/____
 Specialty: _____ X-rays done? Yes No
 Types of treatments received: _____
 How many treatments received? ____ Currently treating: Yes No
 Did treatments benefit you? Yes No
 Last visit date: ____/____/____
 2. Dr. _____ First visit date: ____/____/____
 Types of treatments received: _____
 How many treatments received? ____ Currently treating: Yes No
 Did treatments benefit you? Yes No
 Last visit date: ____/____/____

Additional accident information

If there is additional accident information, please write it in this box. If you need more space, use the back of this page.

Activities of daily living assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty.
 1 = "I can do without any difficulty", 2 = "I can do without much difficulty, despite some pain", 3 = "I manage to do it myself, despite marked pain", 4 = "I manage to do it, despite the pain, but only if I have help", 5 = "I cannot do it all, because of the pain". Only fill in areas affected.

Difficulties with self care and personal hygiene activities
 Bathing ___ Drying hair ___ Brushing teeth ___ Putting on shoes ___ Preparing meals ___ Taking out trash .. ___
 Showering ___ Combing hair ___ Making bed ___ Tying shoes ___ Eating ___ Doing laundry ___
 Washing hair .. ___ Washing face ___ Putting on shirt ___ Putting on pants ___ Cleaning dishes ___ Going to toilet ___

Difficulties with physical activities
 Standing ___ Walking ___ Kneeling ___ Bending back ___ Twisting left ___ Leaning back ___
 Sitting ___ Stooping ___ Reaching ___ Bending left ___ Twisting right ___ Leaning left ___
 Reclining ___ Squatting ___ Bending forward .. ___ Bending right ___ Leaning forward ___ Leaning right ___
 Standing for long periods ___ Sitting for long periods ___ Walking for long periods ___ Kneeling for long periods ___

Difficulties with functional activities
 Carrying small objects ___ Lifting weights off floor ___ Pushing things while seated ___ Exercising upper body ___
 Carrying large objects ___ Lifting weights off table ___ Pushing things while standing .. ___ Exercising lower body ___
 Carrying brief case ___ Climbing stairs ___ Pulling things while seated ___ Exercising arms ___
 Carrying large purse ___ Climbing inclines ___ Pulling things while standing ___ Exercising legs ___

Difficulties with self social and recreational activities
 Bowling ___ Jogging ___ Swimming ___ Ice Skating ___ Competitive Sports .. ___ Dating ___
 Golfing ___ Dancing ___ Skiing ___ Roller Skating ___ Hobbies ___ Dining out ___

Activities of daily living assessment - Part 2

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty. 1 = "I can do without any difficulty", 2 = "I can do without much difficulty, despite some pain", 3 = "I manage to do it myself, despite marked pain", 4 = "I manage to do it, despite the pain, but only if I have help", 5 = "I cannot do it all, because of the pain". Only fill in areas affected.

Difficulties with travelling
 Driving a motor vehicle ___ Riding as a passenger in a motor vehicle ___ Riding as a passenger on a train ___
 Driving for long periods of time ___ Riding as a passenger on an airplane ___ Riding as a passenger for long periods ___

Use the following 1 to 5 scale to describe the difficulties below:
 1 = "This area is not affected by my condition", 2 = "This area is slightly affected by my condition", 3 = "My condition moderately restricts my ability in this area", 4 = " My condition seriously limits my ability in this area", 5 = "My condition prevents me from using this ability"

Difficulties with different forms of communication . Concentrating ___ Hearing ___ Listening ___ Speaking ___ Reading ___ Writing ___ Using a keyboard ___	Difficulties with the Senses Seeing ___ Hearing ___ Sense of touch ___ Sense of taste ___ Sense of smell ___	Difficulties with Hand functions Grasping ___ Holding ___ Pinching ___ Percussive movements ___ Sensory discrimination ___	Difficulties with sleep and sexual function Being able to have normal, restful nights sleep ___ Being able to participate in desired sexual activity ___
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Additional information regarding your activities of daily living (that wasn't covered above):

Prior Symptom History

Prior similar symptoms <input type="checkbox"/> I have NOT had prior symptoms similar to my current complaints. <input type="checkbox"/> My current complaints DID exist before, but have not bothered me. <input type="checkbox"/> My current complaints ALREADY existed and were worsened.	Has your history contributed to your symptoms? <input type="checkbox"/> My history HAS contributed to my current symptoms. <input type="checkbox"/> My history HAS NOT contributed to my current symptoms. <input type="checkbox"/> I'm NOT SURE if my history has contributed to my symptoms.
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My most recent prior similar symptoms (if applicable) occurred _____ months _____ years ... ago / Or on / /

Any other information:

Activities of daily living assessment

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 Listening ___
 Speaking ___
 Reading ___
 Writing ___
 Using a keyboard ___

Difficulties with the Senses

Seeing ___
 Hearing ___
 Sense of touch ___
 Sense of taste ___
 Sense of smell ___

Difficulties with Hand functions

Grasping ___
 Holding ___
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 Percussive movements ___
 Sensory discrimination ___

Difficulties with sleep and sexual function

Being able to have normal, restful nights sleep ___
 Being able to participate in desired sexual activity ___

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- I have NOT had prior symptoms similar to my current complaints.
 My current complaints DID exist before, but have not bothered me.
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Has your history contributed to your symptoms?

- My history HAS contributed to my current symptoms.
 My history HAS NOT contributed to my current symptoms.
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