CONFIDENTIAL PATIENT INFORMATION / Auto Accident

Name_____ **SSN**_____ **Date** _____

Address _____ **City/State** _____ **Zip** _____

D.O.B. _____ **Height/Wt.** _____ **Home Phone** _____

Employer _____ **Occupation** _____ **Work Phone** _____

Message/Cell Phone _____**Spouse/Partner** _____

Whom May We Thank For Referring You to Us _____

Emergency Contact _____ **Phone #** _____

Date of Accident _____ **Time of Accident** _____**AM/PM**

Where Were You Seated _____ **Approx. Damage to Car** _____

Year/Make/Model of Your Car _____

Year/Make/Model of Other Car _____

Visibility at Time of Accident _____ **Poor** _____ **Fair** _____ **Good**

Road Conditions _____**Dry** _____**Wet** _____ **Icy**

Type of Accident (circle): Head On / Rear End / Broad Side / Pedestrian / Rear Ended Car in Front

_____**Non-Collision (describe)** _____

Describe and Draw What Happened

_____

_____

_____

Estimated Speed of Your Vehicle _____MPH. Speed of Other Vehicle_____ MPH

Multi-Car Pile Up _____ # of Cars _____ Loss of Consciousness _____?

Did You Brace For Impact? _____ Were the Brakes On? _____ Did Airbag Deploy? _____

List Any Body Part That Impacted Interior of Car _____

I Was Wearing a: Lap belt? _____ Shoulder Harness_____ or Both _____

Top of Headrest Reached _____ (neck, top of head, etc.)

Describe How You Felt Immediately After _____

Describe How You Felt That Night _____

Describe How You Felt the Next Day _____

Have You Missed Work as a Result? _____ Dates Missed _____

Are You Taking Anything For Pain _____

Have You Ever Experienced Similar Symptoms to What You are Experiencing Now?
Please Describe _____

Have You Seen Other Doctors For This Injury?

Doctor #1 _____ X-Rays Taken? _____

Doctor #2 _____ X-Ray Taken? _____

Were You Taken to the Hospital _____

Dates of Previous Auto Accidents _____

FAMILY HISTORY (list any significant diseases-diabetes, cancer..) Are you Adopted_____

Mother _____ Father _____

Grandparents _____ Aunts/Uncles/Siblings _____

Date of last Physical _____ Any Unusual Findings _____

Women: Are You Pregnant _____ How Far Along _____ Breast Implants _____

Do you Exercise Regularly_____ Types of Exercises _____

Do you smoke/use tobacco? _____ If so, how often? _____

Do you drink alcohol? _____ If so, how often? _____

Chief Complaint _____

ONSET (what were you doing when injury occurred) _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other ___
_____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other __
_____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____

Complaint #2 _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other ___
_____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other __
_____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____

CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD

_____ **Headache**
_____ **Allergies**
_____ **Dizziness**
_____ **Deafness**
_____ **Ringing in Ears**
_____ **Loss of Balance**

_____ **Fainting**
_____ **Eye Pain**
_____ **Failing Vision**
_____ **Nosebleeds**
_____ **Sinus Infection**

CHEST

_____ **Chest Pain**
_____ **Difficulty Breathing**
_____ **Asthma**

ABDOMEN

_____ **Difficult Digestion**
_____ **Abdominal Cramps**
_____ **Diarrhea**
_____ **Constipation**
_____ **Nausea**
_____ **Change in Urinary Function**
_____ **Change in Bowel Function**

OTHER

_____ **Loss of Sleep**
_____ **Nervousness**
_____ **Depression**
_____ **Fever**
_____ **Change in Menstrual Cycle**
_____ **Pregnant**
_____ **Hemorrhoids**
_____ **HIV+/ Aids**
_____ **Other** _____

PLEASE CHECK ANY OF THE FOLLOWING YOU'VE HAD

_____ **Alcoholism**
_____ **Appendectomy**
_____ **Cancer**
_____ **Diphtheria**
_____ **Gall Bladder Problems**
_____ **Heart Disease**
_____ **Liver Problems**
_____ **Multiple Sclerosis**
_____ **Polio**
_____ **Thyroid Trouble**
_____ **Venereal Disease**

_____ **Allergies**
_____ **Arteriosclerosis**
_____ **Colitis**
_____ **Eczema**
_____ **Goiter**
_____ **Hepatitis**
_____ **Malaria**
_____ **Pleurisy**
_____ **Prostate Problems**
_____ **Tuberculosis**
_____ **Whooping Cough**

_____ **Anemia**
_____ **Arthritis**
_____ **Diabetes**
_____ **Emphysema**
_____ **Epilepsy**
_____ **Kidney Stone/ Infection**
_____ **Migraines**
_____ **Pneumonia**
_____ **Scarlet Fever**
_____ **Ulcers**

Signature _____ **Date** _____