PATIENT INFORMATION

Name: _____ **Date:** _____

Home Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email Address:** _____

Social Security: _____ **Age:** _____ **Date of Birth:** _____

Home Phone: _____

Cellular Phone: _____ **Male:** ☐ **Female:** ☐

Employer: _____ **Position:** _____

Employer Phone Number: _____

Employer Address: _____ **City/State:** _____ **Zip:** _____

Spouse: _____ **Spouse's Employer:** _____

INSURANCE INFORMATION

__Major Medical __PPO __HMO __Car Accident Policy __Work Comp. __None

Insurance Co.: _____ Group #: _____ Policy# _____

Name of Insured: _____ Social Security #: _____

Is this problem due to a specific accident? __Yes __No

Type of accident: __Car Accident __Work Injury __Slip & Fall __Home Injury

Date of Injury: _____ Time: _____ Where did it happen? _____

Have you retained an attorney? __Yes __No Name of Attorney: _____

If injured on the job, did you notify supervisor/employer? __Yes __No Date: _____

If injured on the job, was an injury report filled out? __Yes __No

Do you have a claim number for the above accident? __Yes __No Claim #: _____

Information of Present Complaint(s)

My pain is relieved by:
__Applying Ice __Applying Heat __Rest __Stretching

__Medications (Please list medications):_____

__Nothing relieves my pain. __I have not tried anything for my pain.

Have you seen any doctor(s) for your current complaints of pain, including emergency room visits? __No
__Yes (Please list any/all doctor(s) you have seen for you current pain):

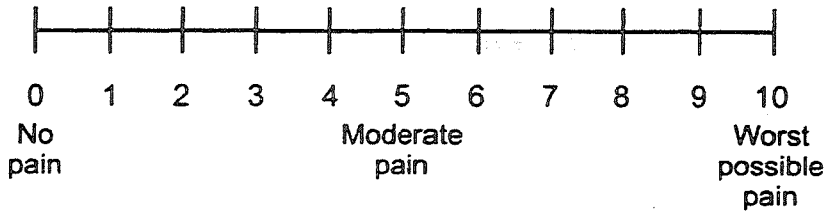
_____

_____

0 – 10 Numeric Pain Intensity Scale

Please circle an area on the pain scale below that best represents the amount of pain you are experiencing now.

0-10 Numeric Pain Intensity Scale*



Height: _____ Weight: _____ __Right Handed __Left Handed

Do you have a history of High Blood Pressure? __Yes __No History of Stroke? __Yes __No
Do you have any family members who suffer from High Blood Pressure? __Yes __No
Have any of your family members suffered a stroke? __Yes __No
Are you allergic to any medications? __Yes __No (If yes, List_____)

Past Medical History

List any/all past operations or surgical procedures:

Operations	Date (on or about)
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been involved in any other personal injury, motor vehicle accident or work related accident in the past? __Yes __No (If yes, please provide dates of accidents, injuries, treatment you received and results of that treatment.)

Personal Injury/Motor Vehicle Accidents/Slip & Fall Accidents:

_____

_____

_____

Work Related Accidents:

_____

_____

_____

Are you currently under the care of any doctor at this time for any of the above accidents? __Yes __No
If yes, please list any/all doctor's name.

_____

_____

Medical Rehab
Accident Injury Center

Today's Date _____

ACCIDENT QUESTIONNAIRE

NAME_____ Date of Accident _____

1. What kind of car were you in?

___Compact

___Mid-size

___Full size

___SUV

___Mini-van

___Pick-Up Truck

___Bus

2. What was the other vehicle?

___Compact

___Mid-size

___Full size

___SUV

___Mini-van

___Pick-Up Truck

___Bus

3. Was the car accident unexpected?

_____Yes _____No

Did your body strike any part of the inside of the vehicle?

_____Yes _____No

Body Part?

_____

4. Did you hit anything else after the first impact?

___ Yes ___ No

___ Another vehicle

___ Other _____

_____

5. At the time of the crash what was your vehicle doing?

___Sitting at a stop sign/stop light

___Stopped in traffic or stopped for another reason

___Moving with traffic

___Crossing an intersection

___Turning

___ Other _____

6. How was your vehicle hit?

___ From behind/rear impact

___ From the front/front impact

___ From the driver's side

___ From the passenger's side

___ Other _____

_____

Medical Rehab
Accident Injury Center

Today's Date _____

7. What was the weather like when your crash happened?

___ Raining or recently rained

___ Misting or recently misty

___ Dry

8. What was the street condition?

___ Wet/slick

___Dry

9. Where were you in the car?

___ Driver

___ Front seat passenger

___ Passenger in back seat on driver's side

___ Passenger in back seat on passenger's side

___ Passenger in back seat in the middle

___ Passenger in 3rd row of SUV or mini-van

___ Passenger in car-seat

___ Passenger in booster seat

10. Were you wearing a seat belt?

___ Yes ___ No

What kind of seat belt were you wearing?

___ Lap/Shoulder

___Shoulder only

___Lap only

11. Were you hit by an airbag?

___ Yes ___ No

If yes, where were you hit?

___ Head/face/neck

___ Arm/forearm/shoulder

12. What was your body position?

___Facing forward

___Turned to right or left

___Leaning forward

___Slouching in seat

13. Did you go to a hospital or doctor after the crash?

___ Yes ___ No

What hospital/doctor? _____

_____

14. What was your head position?

___Looking forward

___Head turned up ___Head turned down

___Head turned right ___Head turned left

Medical Rehab
Accident Injury Center

Today's Date _____

Symptoms

NAME_____ Date of Accident _____

INSTRUCTIONS: Check any symptom you have felt at any time since your car accident

1. HEAD INJURIES

___I was unconscious
___Did you strike your head on anything?
If yes, what? _____
___Headaches
___Dizziness
___Difficulty walking NOT due to back pain
___Balance problems
___Confused
___Sensitive to noise
___Sensitive to light
___Trouble concentrating
___Trouble remembering
___Trouble speaking

___Fatigued
___Appetite changed
___Sleeping more than usual
___Sleeping less than usual
___Vision problems; blurry, double vision
___Trouble reading or writing
___Nausea
___Vomiting
___Depressed
___Mood swings
___Irritable

2. CUTS OR BRUISES

___Head or face cut/bruise
___Chest cut/bruise
___Arms cut/bruise
___Legs cut/bruise
___Seat belt bruise or chest pain from seat belt cut/bruise
___Other cuts or bruises _____

___Neck cut/bruise
___Abdomen cut/bruise
___Hands cut/bruise
___Feet cut/bruise

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3. JAW PROBLEMS

___Jaw pain

___Clicking

___Pain while opening and/or closing mouth

___Clicking while opening and/or closing mouth

___Pain while moving jaw from side to side

4. NECK/UPPER BACK

___ Neck pain ___Right side ___Left side ___Both sides

___Upper back pain ___Right side ___Left side ___Both sides

___Pain/tingling/numbness radiating into the RIGHT shoulder, arm, forearm or hand

___Pain/tingling/numbness radiating into the LEFT shoulder, arm, forearm or hand

___Popping/clicking in neck

5. MID-BACK/LOWER BACK PAIN

___Mid-back pain ___Right side ___Left side ___Both sides

___Low back pain ___Right side ___Left side ___Both sides

___Pain/tingling/numbness into the RIGHT buttock, thigh, leg or foot

___Pain/tingling/numbness into the LEFT buttock, thigh, leg or foot

6. OTHER AREAS OF PAIN

___Right shoulder	___Right wrist	___Right hip	___Right leg
___Left shoulder	___Left wrist	___Left hip	___Left leg
___Right elbow	___Right hand	___Right knee	___Right ankle/foot
___Left elbow	___Left hand	___Left knee	___Left ankle/foot

Updated May 2018

Loss of Enjoyment, Duties Performed Under Duress, Interrupted Daily Activities

Name: _____ Date of injury: _____

___ Initial ___ Updated

Please CHECK ALL activities that cause you pain due to your accident:

___ Sitting ___ Kneeling

___ Standing ___ Turning head left or right

___ Lying down ___ Holding up head all day

___ Bending ___ Sexual activity

___ Exercise ___ Leaning forward

___ Stooping ___Getting dressed

___ Squatting down ___ Driving

Please check all that apply to your WORK because of the accident:

___ I have missed work due to the accident ___ I go to work in pain

_____ Number of days missed ___ I have had to take unpaid time off

___ I make mistakes I do not usually make

Please check all that apply to your SCHOOL because of the accident:

___I have missed school due to the accident ___ I go to school in pain

___ Number of days missed ___ My grades are lower since the accident

___ I have difficulty concentrating in class

Please check all that apply to your HOME/DOMESTIC because of the accident:

___I have difficulty cleaning my home now

___ I cannot work in my yard now

___ I have had to hire someone to assist me with my household chores

Please check all that apply to your TRAVEL because of the accident:

___I have had to reschedule trips (Business/Personal) ___I cannot fly in an airplane

___ I am in too much pain to drive long distances ___ I have anxiety while in the car

Patient Signature: _____ Today's Date:_____