Name:____ Today's Date:__________________________

Date of Accident:______________________________________

Please circle answers or fill in the space. If you can't or don't answer a question please put a check by it.

Describe the collision in your own words:____

____

____

____

What was your position in car? DRIVER PASSENGE If passenger, were you sitting in the FRONT BACK RIGHT/LEFT REAR Did your vehicle strike another vehicle? YES NO. Was your car struck by other vehicle? YES NO.

Was impact from FRONT RIGHT SIDE LEFT SIDE REAR. Was your car pushed FORWARD or SIDEWAYS? If yes, how much: LESS THAT 1/2 CAR LENGTH 1/2 CAR LENGTH ONE CAR LENGTH MORE THAN ONE CAR LENGTH

At the time of the impact were you: LOOKING STRAIGHT AHEAD LOOKING RIGHT LOOKING LEFT

Was the trunk of your body pointed forward? YES NO If no, what direction was it turned? LEFT RIGHT REAR

If you were the driver, were both hands on the steering wheel? YES NO If not, where__________________________________

Was your foot on the break? YES NO If you were a passenger, was the drivers foot on the break? YES NO UNKNOWN

Were you aware or surprised for the impact? AWARE SURPRISED Where in the car were you after the accident?_______

____

Were you wearing a seat belt? YES NO If yes, was it LAP BELT ONLY or SHOULDER AND LAP BELT

Did you receive any injury or bruise from the seat belt? (i.e. breast or abdomen)? YES NO If yes, please describe_________

____

Does your vehicle have an air bag? YES NO If yes, did the air bag deploy? YES NO Did you receive any injuries from the air bag? YES NO If yes, please describe____

Did you strike anything in the vehicle at the time of impact? YES NO On what part of the automobile did your following parts hit? Head hit____________________________________ Chest hit____

Right/left shoulder hit________________________________ Right/left arm hit_________________________________

Right/left hip hit______________________________________ Other____

Did things fly around in the car upon impact(i.e. ashtray, glove box opened, mirror flew off)________________________________

____

What is the approximate distance between the back of your head and your seat's headrest?______________________ inches.

How are is the headrest from the top of your head? approximately ____________inches above, ______________ inches below

Number of other people in the vehicle you were in? ___________________________

The road surface at the time of accident: WET DRY ICY PAVEMENT GRAVEL DIRT OTHER____________________________

List the year______________________ make ____________________and model _______________________of the car you were in.

Was your car stopped at the time of impact? YES NO If no, estimate the speed of the vehicle you were in _________ mph.

Was the vehicle you were in SLOWING DOWN GAINING SPEED or traveling at a STEADY RATE of speed.

What was the estimated cost damage to the vehicle you were in? ______________$

Which of the following car parts broke during the accident? WINDSHIELD FRONT SEAT STEERING WHEEL RIGHT/LEFT WINDOW REAR WINDOW OTHER: ____

What is the year____________________ make_____________________ model__________________________ of the other vehicle?

Was the other vehicle SMALLER LARGER or SIMILAR in size?

The other vehicle was TOTALED or had MAJOR DAMAGE MINOR DAMAGE SOME BROKEN PARTS (lists):_______________

Was the other vehicle SLOWING DOWN GAINING SPEED or traveling at a STEADY RATE at the time of impact?

The approximate speed of the other vehicle was ____________ mph.

The posted speed limit was ______________mph or UNKNOWN.

Did the police come to the accident scene? YES NO. Was the accident report filled out? YES NO.

Were you checked at the scene for injuries by FIREMAN PARAMEDIC POLICE or by NO ONE (Please circle)

Did you go to the hospital? YES NO. If yes, who took you? SELF PARAMEDICS SOMEONE ELSE(name)_______________

When? ____

The name of the hospital: ____________________________in (city) _________________ How long did you stay? ________________

What parts of you body were x-rayed at the hospital? ____NONE.

Did they tell you what was wrong (give you a diagnosis) ____

Did they give you prescription medication? YES NO. If yes, list: ____

What else did the hospital do for your injuries? ____NOTHING.

Attended by Doctor: _______________________. Who recommended I see: my OWN DOCTOR or see someone else who is an

ORTHOPEDIST NEUROLOGIST PHYSICAL THERAPIST OTHER____

Who else have you seen as a result of this accident?____

____

When did you see them? ____

What was their treatment or recommendations? ____ Has it helped? YES NO

What bleeding cuts did you sustain during the accident? ____ NONE.

What bruises did you sustain during this accident? ____NONE.

Did you lose consciousness (black out) upon impact? YES NO. How long? ____

Do you remember the actual collision? YES NO. Did you experience a flash of light or explosion in your head? YES NO.

Did you become CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED BLURRED VISION

RING/BUZZ IN EARS from the accident? (please circle)

Immediately following the accident how, or what, else did you feel? ____

____

What other symptoms did you notice over the next 3-5 days? ____

____

CURRENT STATUS

Are you **currently** suffering from any of the following (please mark): You can skip this part if your accident was within the past two weeks.

- ☐ **HEADACHES**
- ☐ **NECK PAIN**
- ☐ **NECK STIFF**
- ☐ **UPPER BACK PAIN**
- ☐ **MID BACK PAIN**
- ☐ **LOWER BACK PAIN**
- ☐ **ABDOMINAL PAIN**
- ☐ **NERVOUSNESS**
- ☐ **TENSION**
- ☐ **IRRITABILITY**
- ☐ **CHEST PAIN**
- ☐ **DIZZINESS**
- ☐ **HEAD SEEMS TOO HEAVY**
- ☐ **SHORTNESS OF BREATH**
- ☐ **FATIGUE**
- ☐ **DEPRESSION**
- ☐ **LIGHT BOTHERS EYES**
- ☐ **DIFFICULTY W/ MEMORY**
- ☐ **CAN'T CONCENTRATE**
- ☐ **FORGETFULNESS**
- ☐ **EARS RING OR BUZZ**
- ☐ **FACE FLUSHED**
- ☐ **LOSS OF BALANCE**
- ☐ **FAINTING SPELLS**
- ☐ **LOSS OF SMELL**
- ☐ **LOSS OF TASTE**
- ☐ **DIARRHEA**
- ☐ **COLD FEET**
- ☐ **COLD HANDS**
- ☐ **UPSET STOMACH/NAUSEA**
- ☐ **CONSTIPATION**
- ☐ **COLD SWEATS**
- ☐ **FEVER**
- ☐ **HEAT INTOLERANCE**
- ☐ **SLEEPING PROBLEMS**
- ☐ **ALCOHOL INTOLERANCE**
- ☐ **CONFUSED**
- ☐ **LIGHT HEADED**
- ☐ **BLURRED VISION**
- ☐ **DISORIENTED**
- ☐ ___________________________
- ☐ ___________________________
- ☐ ___________________________

Do you have areas of numbness or tingling: RIGHT/LEFT ARM RIGHT/LEFT HAND RIGHT/LEFT FINGERS (1-2-3-4-5)

RIGHT/LEFT LEG RIGHT/LEFT FOOT RIGHT/LEFT TOES (1-2-3-4-5) FACE OTHER___________________________

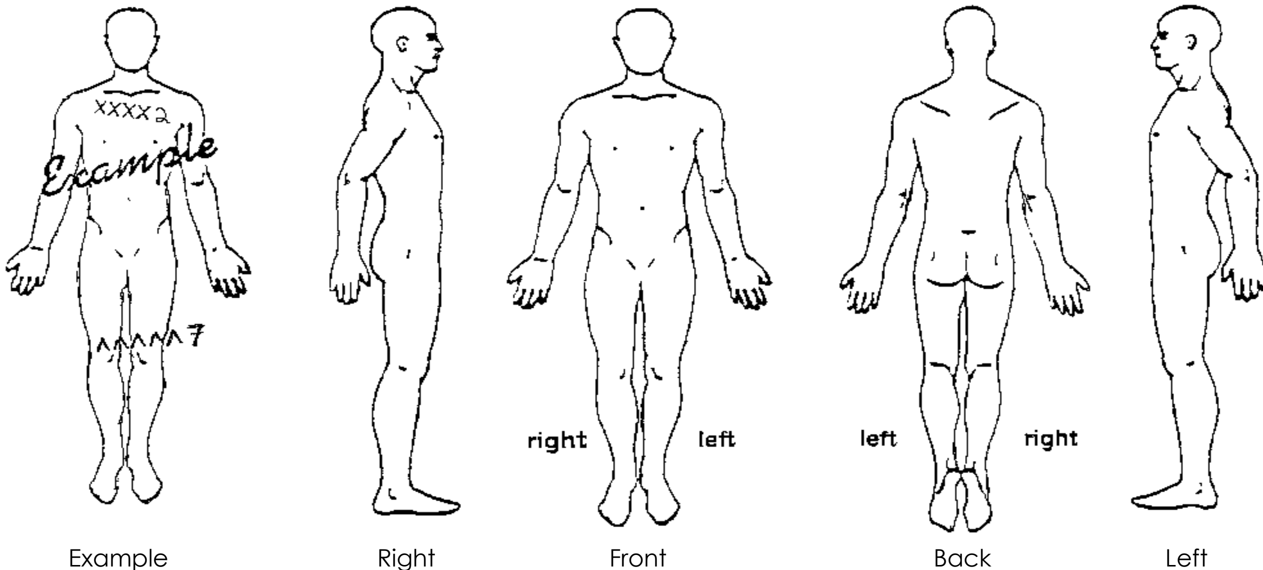
Do any of the following ache or hurt: RIGHT/LEFT SHOULDER RIGHT/LEFT ELBOW RIGHT/LEFT WRIST

RIGHT/LEFT HIP JOINT RIGHT/LEFT KNEE RIGHT/LEFT ANKLE

Do you have cramps in your LEGS FEET ARM ABDOMEN. Have you had any changes in your bowel habits? YES NO.

PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT USING THE FOLLOWING CODE:

Numbness	Pins and Needles	Burning	Aching	Stabbing	Throbbing	Intense Pain
NNNN	**OOOO**	**XXXX**	**++++**	**////**	**####**	**>>>>**



INDICATE THE DEGREE OF PAIN USING A SCALE OF 1(MILD DISCOMFORT) TO 10 (EXTREME PAIN) FOR EACH AREA THEN LABLE EACH AREA OR REGION IN ORDER OF IMPORTANCE OR SEVERITY TO YOU (A, B, C, ETC.)

Current symptoms other than above: ____

____

____

What is your overall sense of the pain (for the primary area or major complaint) MILD NUISANCE MILD TO MODERATE, BUT I CAM LIVE WITH IT MODERATE, HAVING TROUBLE DEALING WITH IT SEVERE, IT IS RUINING MY QUALITY OF LIFE

Is your pain constant (primary complaint area?) YES NO Is your pain off and on? YES NO

How many days per week does this condition(s) bother you? _____________ How many hours per day? _____________

Is the primary complaint pain SHARP or DULL (please circle) Describe other characteristics of your pain:____________

____

____

____

____

Is your pain worse when arising from a chair? YES NO Is it made worse by straining? YES NO By coughing? YES NO

By sneezing? YES NO By straining when moving your bowels? YES NO

Is your pain worse with prolonged: SITTING STANDING DRIVING WALKING SLEEPING OTHER__________________________

Do any of these activities worsen the pain? STRETCHING REACHING LIFTING BENDING TWISTING/TURNING SEX MOVING CHANGING POSITIONS LOOKING UP LOOKING DOWN OTHER_____________________________________

What is your most comfortable position? SITTING STANDING LAYING ON RIGHT/LEFT SIDE LAYING ON BACK/STOMACH

Do you feel better MOVING AROUND RESTING Do you feel better in the MORNING EVENING NO CHANGE DURING DAY

Do any of the following relieve your pain? HEATING PAD ICE HOT BATH SHOWER STRECHES MASSAGE ALCOHOL

OTHER (what do you do to relieve the pain?) ____________________

If you are taking over the counter medication for these injuries, list what kind, how much and how often:____________________

____

If you are using a brace or support does it help relieve the pain? YES NO What type of support:____________________

Does a change in heel height worsen the pain? YES NO Do you have normal sexual function? YES NO UNCERTIAN

Are you able to take care of your personal self such as dressing, and bathing, etc? YES NO

How is the pain compared to when it first started: MUCH IMPROVED SOMEWHAT IMPROVED NO CHANCE A LITTLE WORSE MUCH WORSE How often do you have to stop what you are doing to sit, lay down, stretch, etc. to control the symptoms? CONSTANTLY SEVERAL TIMES PER DAY OCCASIONALLY ONCE OR TWICE PER DAY

I DON'T HAVE TO STOP What other activities or hobbies (recreational, exercise, house or yard chores, etc) did you do before the accident that you find difficult or can't do now because of your injuries: ____________________

____

____

Do you currently do a routine stretch or exercise program? YES NO If yes, briefly describe what you do and how often:

____

____

____

OCCUPATIONAL HISTORY

Have you lost any time at work because of this accident? YES NO

If yes, give dates of time lost. From ____________________ To ____________________

What is your Occupation: ____________________

Name of Employer:____________________ City/town you work: ____________________

How many hours are in your normal work day (before accident)? ____________ How many since? ____________ SAME

I normally start work at__________ am pm and get off at ____________ am pm

My commute time is usually ______________ min. on the way to work and ______________ am pm

Please indicate your daily job duties, activities and average hours you are asked to perform them.

☐ STANDING ________ HRS
☐ TWISTING ________ HRS
☐ TYPING ________ HRS
☐ SITTING ________ HRS
☐ CRAWLING ________ HRS
☐ PHONE ________ HRS
☐ WALKING ________ HRS
☐ BENDING ________ HRS
☐ LIFTING ________ HRS
☐ OPERATING EQUIPMENT ________ HRS
☐ DRIVING ________ HRS
☐ WORK W/ARMS OVER HEAD ________ HRS
☐ OTHER ____________________

____

If necessary, what positions can you work in with minimal physical effort and for how long? ____________________

____

____

Prior to the accident were you capable or working on an equal basis with others your age? YES NO

Is your job physically stressful? YES NO Is your job mentally stressful? YES NO Is your work place noisy? YES NO

How satisfied are you with your job? VERY SOMEWHAT NEUTRAL NOT AT ALL NO COMMENT

Have you had to change jobs because of injuries? YES NO If yes why? ____

If you continue to work, is it WITH or WITHOUT Difficulty? Describe what is difficult at work: ______________________________

____

____

Do you work with others who can help you with heavy lifting? YES NO

While in recovery, is there any light duty work you could request? YES NO

Are there any other comments regarding your injuries, the accident or about your health that you want the Doctor to know about?____

____

____

____

____

____

____

____

____

____

Signature ____ Today's Date ____________________________________