PATIENT INFORMATION

Name _____ Today's Date _____

Date of Birth _____ Height _____ Weight _____ Dominant Hand? R L

Address _____ City _____ Zip _____

Phone (cell) _____ Phone (other) _____

email _____ DL# _____

Health Insurance Company _____ Policy# _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Car Insurance Company _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Agent _____ Phone _____

Policy # _____ Claim # _____

What Medical Payments Coverage? _____ What Uninsured Motorist Coverage? _____

What Law Firm Represents You? _____

Address _____ City _____ Zip _____

Your Lawyer's Name? _____ Phone _____

Name of Insured on your Car Policy _____

For office use only
Patient #

Date of Loss/Accident? _____ Date you first saw *any* Doctor after accident _____

Cost of all medical treatment since the accident? $ _____

How much income have you lost since the accident $ _____

What is the property damage (repair amount) of your car? $ _____

Name of your Personal M.D. _____ Phone _____

Address _____ City _____ Zip _____

Write any Ambulance, Hospital, M.D., Chiropractor, Dentist, Acupuncturist, PT, etc., since accident

Name	Type	Phone#	Amount of Bill	For office use only Records Rec'd

Please use other side of page to write additional doctors & hospitals

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have that you did not have before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

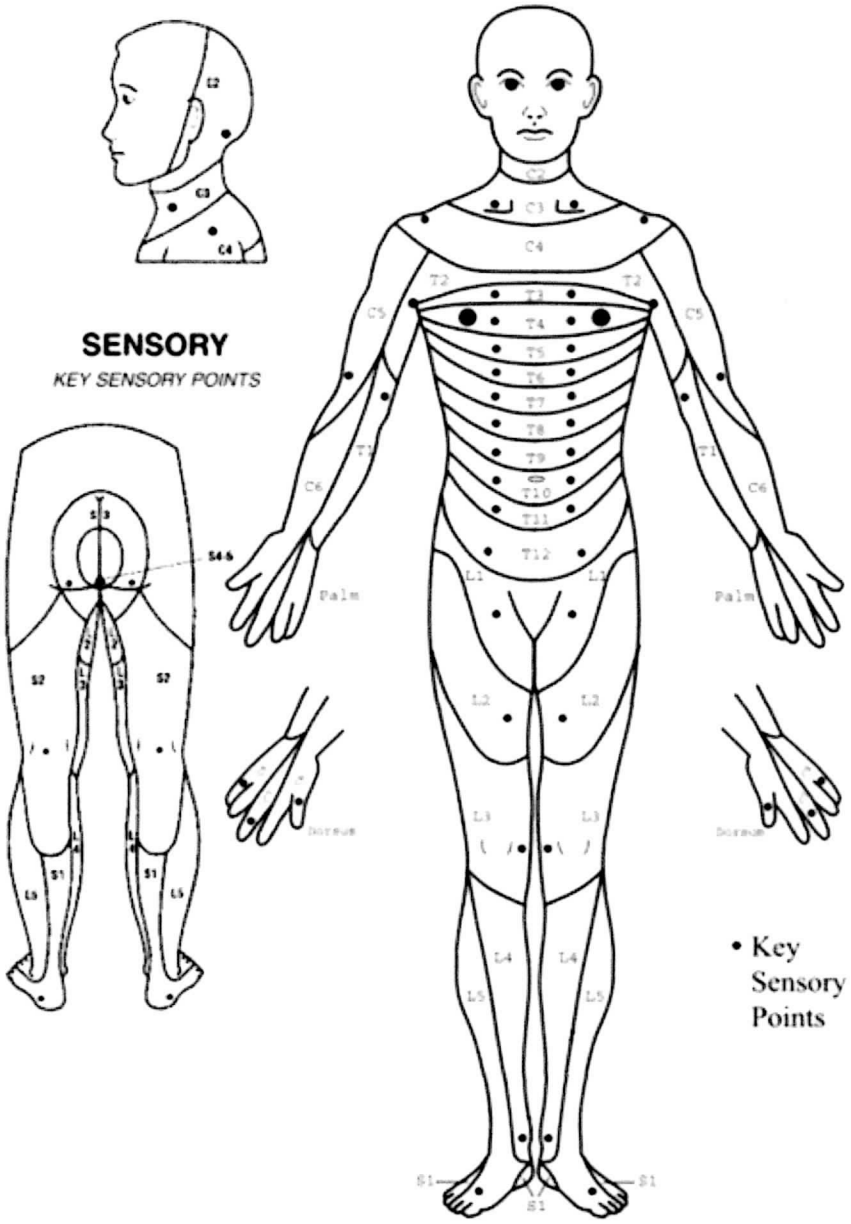
Patient_____ Date_____ DOI_____

Please shade in all areas where you have had **RADIATING PAIN (Pain that Travel's or Shooting Pain)** in the past 7 days

Radiating Pain is: ☐ Sharp L R ☐ Dull L R ☐ Ache L R ☐ Other _____

Percent of time you have this: ☐ 25% ☐ 50% ☐ 75% ☐ 100 % ☐ Other ___%

RIGHT **LEFT**



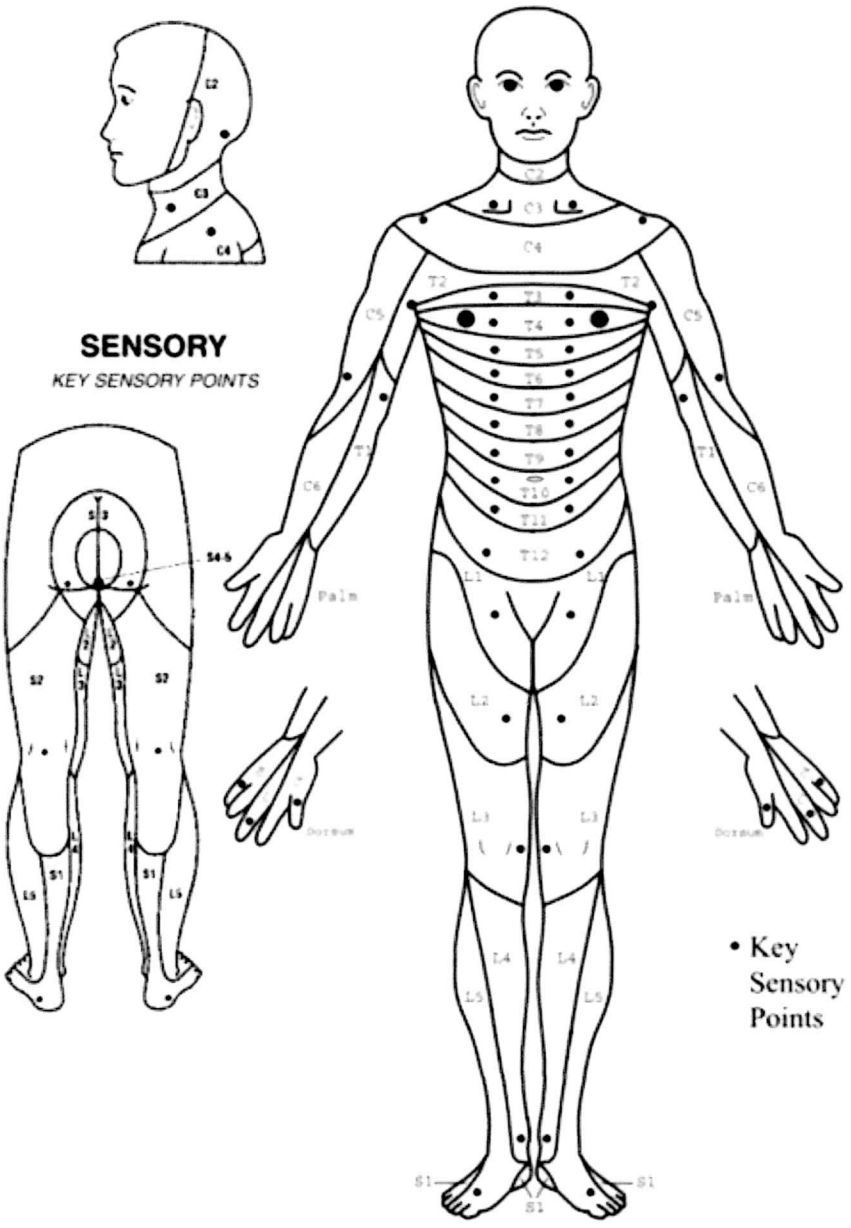
Patient_____ Date_____ DOI_____

Shade in all areas of **ALTERED SENSATION** (i.e. Pins/Needles, Numbness, Tingling)

☐ Pins/Needles L R ☐ Tingling L R ☐ Numbness L R ☐ Other _____

Percent of time you have this: ☐ 25% ☐ 50% ☐ 75% ☐ 100 % ☐ Other ___%

RIGHT **LEFT**



☐ Do you have any **WEAKNESS** in any of the Following:

Weakness:	☐ Shoulder Left	☐ Shoulder Right
	☐ Elbow Left	☐ Elbow Right
	☐ Wrist Left	☐ Wrist Right
	☐ Hand Left	☐ Hand Right
	☐ Hips Left	☐ Hips Right
	☐ Knees Left	☐ Knees Right
	☐ Ankle Left	☐ Ankle Right
	☐ Feet Left	☐ Feet Right

Percent of time you have this: ☐ 25% ☐ 50% ☐ 75% ☐ 100 % ☐ Other ___%

Patient's Name:______________________________ Today's Date:____________

Patient History Form

1. Have you been involved in a prior motor vehicle collision(s)? ☐ Yes ☐ No
   If "Yes", please specify what year(s), what body area(s) was injured, did you have treatment, did injuries resolve or do you have residual problems/symptoms (describe treatment):

   ☐ Year_____ Body area(s) injured?____
   Treatment? ☐ Yes ☐ No Describe treatment:_________________________________
   Injury Resolved? ☐ Yes ☐ No Residual Symptoms? ☐ Yes ☐ No MRI done? ☐ Yes ☐ No

   ☐ Year_____ Body area(s) injured?____
   Treatment? ☐ Yes ☐ No Describe treatment:_________________________________
   Injury Resolved? ☐ Yes ☐ No Residual Symptoms? ☐ Yes ☐ No MRI done? ☐ Yes ☐ No

   ☐ Year_____ Body area(s) injured?____
   Treatment? ☐ Yes ☐ No Describe treatment:_________________________________
   Injury Resolved? ☐ Yes ☐ No Residual Symptoms? ☐ Yes ☐ No MRI done? ☐ Yes ☐ No

2. Please list <u>any and all</u> past injuries or traumas:____________________________________
   ____
   ____

3. Please describe any pre-injury symptoms in the body parts in which you currently have symptoms:
   ____
   ____
   ____

4. Please list any past surgeries even if unrelated to present injuries:

Date	Type of Surgery
______________	____
______________	____
______________	____

5. Please list any medication (both other-the-counter and prescription) you are currently taking:

Medication	Reason for taking
________________________	______________________________
________________________	______________________________
________________________	______________________________

____________________________________ ________________________
Patient or Guardian Signature Date

Patient's Name:_____ Today's Date:_____

Auto Collision Mechanism of Injury

1. Date of Accident:_____ Hour of Accident:_____ AM / PM

2. Please describe how the accident happened:_____
_____
_____
_____

3. What was your position in the car? ☐ Driver ☐ Front Passenger ☐ Left Rear ☐ Right Rear

4. If "Driver", were your hands on the steering wheel? ☐ Both ☐ Left ☐ Right

5. Did airbags deploy in your vehicle? ☐ Yes ☐ No

6. Did another vehicle strike your vehicle? ☐ Yes ☐ No If Yes: ☐ Car ☐ Truck ☐_____

7. Did you strike another vehicle? ☐ Yes ☐ No If Yes: ☐ Car ☐ Truck ☐_____

8. Mark any object(s) which your vehicle struck during the course of your collision:
☐ Wall ☐ Road Barrier ☐ Tree ☐ Other_____ ☐ Other_____

9. Angle of impact: ☐ Front ☐ Back (rear) ☐ Left ☐ Right ☐ Other:_____

10. If 2nd collision – angle of impact: ☐ Front ☐ Back ☐ Left ☐ Right ☐ Other_____
If 3rd collision – angle of impact: ☐ Front ☐ Back ☐ Left ☐ Right ☐ Other_____
If 4th collision – angle of impact: ☐ Front ☐ Back ☐ Left ☐ Right ☐ Other_____

11. In relation to the back of your head, was your headrest set: ☐ Low ☐ Middle ☐ High

12. Were you surprised by the impact? ☐ Yes ☐ No
If "NO", how did you brace? ☐ with hands ☐ with feet

13. Where was your head facing at the time of the impact?☐ Straight ahead ☐Left ☐ Right ☐ Behind

14. Were you leaning forward at the time of the accident? ☐ Yes ☐ No

15. Do you know what motions your body was moved during the impact? (Check all that apply)
☐ Back and Forth ☐ Forward and back ☐ Side to side ☐ Rotation to right ☐ Rotation to left

16. What type and year of vehicle were you in?_____

17. What was the approximate speed of your vehicle when the collision occurred? _____ mph

18. What type and year of vehicle struck yours? _____

19. What was the approximate speed of the other vehicle when the collision occurred? _____ mph

20. Were you wearing your seatbelt? ☐ Yes ☐ No What type: ☐ Lap belt ☐ Shoulder belt ☐ Both

21. Did you feel symptoms immediately after the accident: ☐ Yes ☐ No

22. As a result of the collision were you?
☐ Unconscious or "Blacked Out" ☐ Dazed ☐ Confused ☐ In shock

23. Did you strike anything in the vehicle at the time of the impact? ☐ Yes ☐ No
If "Yes", specify what part of your body struck what (i.e. head, chest, chin, shoulder, knee, etc.)
☐ Steering Wheel: _____ ☐ Windshield: _____
☐ Dashboard: _____ ☐ Roof: _____
☐ Left Side Door: _____ ☐ Right Side Door: _____
☐ Left Window: _____ ☐ Right Window: _____
☐ Other: _____

24. Did your seat break or bend? ☐ Yes ☐ No

25. Immediately following the collision, how did you feel? (Mark all that apply)
☐ Dizzy ☐ Dazed ☐ Weak ☐ Upset ☐ Disoriented ☐ Confused ☐ Nervous ☐ Nauseous
☐ Vomiting ☐ Ringing in the ears ☐ Other: _____

26. Did emergency services respond to the accident? ☐ Yes ☐ No (Check all that apply)
☐ Police – Is there a police report? ☐ Yes ☐ No
☐ Fire Department – Did you require assistance or extraction from your vehicle? ☐ Yes ☐ No
☐ Paramedics/Ambulance
☐ Treated at scene and released
☐ Transported to hospital
☐ Other _____

27. If transported to the hospital, please check all that apply:
☐ Treated and released ☐ X-rays ☐ CT scan ☐ MRI ☐ Prescribed medication ☐ Stitches
☐ Recommended to follow-up with doctor ☐ Surgery ☐ Hospitalized (How many days?____)
☐ Other _____

28. Mark all vehicles involved in the collision which had to be towed away by a tow truck?
☐ Your Car ☐ Other Vehicle ☐_____ ☐_____

29. Mark all vehicles involved in the collision which had a trailer hitch?
☐ Your Car ☐ Other Vehicle ☐_____ ☐_____

_____ _____
Patient or Guardian Signature Date