INITIAL EVALUATION – Automobile Accident

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

What brings you into our office? ☒ **Automobile Accident**

When did this accident happened? _____

What was your position in the vehicle?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger
☐ Middle Front Passenger ☐ Middle Rear Passenger ☐ Right Rear Passenger

What was the damage to the vehicle? ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled

How was the visibility on the road? ☐ Poor ☐ Fair ☐ Good

And the weather was:

☐ Clear ☐ Raining ☐ Windy ☐ Foggy ☐ Snowing

How did the accident happen?

☐ You hit another vehicle ☐ Another vehicle hit you ☐ You hit another object

What was the point of impact on our vehicle?

☐ Left ☐ Front end ☐ Rear End ☐ Right
☐ Left front ☐ Left rear ☐ Right front ☐ Right rear

Did you see the accident coming? ☐ Yes ☐ No

Were you braced for the impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, Does the seatbelt have a shoulder strap? ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No

Did it deploy during the accident? ☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No
If yes, positioned: ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

Did you strike anything inside the vehicle? ☐ Yes ☐ No

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What inside your vehicle id you strike? ☐ Wheel ☐ Windshield ☐ Arm rest ☐ Dashboard
☐ Side Door ☐ Side window ☐ Airbag

Immediately after the accident, did you feel dazed? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Which way was your head turned during the accident?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Was your head injured? ☐ Yes ☐ No

Immediately after the accident, did you experience: ☐ Headache ☐ Neck Paid ☐ Low Back Pain

Did you see another doctor before coming here? ☐ Yes ☐ No

Did you go to a hospital after the accident? ☐ Yes ☐ No If yes, which hospital? _____

How did you get to the hospital? ☐ Ambulance ☐ Drove self ☐ Somebody else ☐ Police

Were any of the following tests performed at the hospital?
☐ X-Rays ☐ MRI ☐ CT Scan ☐ Lab Work

Do you feel your condition is:☐ Improving ☐ Staying the same ☐ Getting Worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities: ☐ Yes ☐ No
If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

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Activities of Daily Living *Please select all activities which you are currently experiencing problems:*

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating	☐ Hearing	☐ Insomnia
☐Dressing	☐Reading	☐Typing	☐Writing	☐Grasping	☐ Using the toilet
☐ Standing	☐ Leaning	☐ Walking	☐ Stooping	☐ Squatting	☐ Loss of Sexual Drive
☐ Bending	☐ Twisting	☐ Carrying	☐ Lifting	☐ Pushing	☐ Restful sleeping
☐ Sitting	☐ Driving	☐ Sports	☐ Exercising	☐ Reclining	☐ Loss of concentration
☐ Irritable	☐ Riding in car	☐ Air Travel	☐ Climbing	☐ Pulling	☐ Changes in personality
☐ Grooming	☐ Pinching	☐ Kneeling	☐ Reaching	☐ Nervous	☐ Tactile feeling
☐ Bathing	☐ Holding				

Past Medical History *Please select all conditions that you have had or are currently having:*

☐None	☐Other	☐Abdominal pain	☐Abnormal Weight gain/loss	☐Angina
☐Anorexia	☐Anxiety	☐Aortic aneurysm	☐Arthritis	☐Asthma
☐Bladder infection	☐Blood disorder	☐Brest lumps	☐Breast Soreness	☐Bronchitis
☐Cancer	☐Cardiovascular disease/heart attack	☐Chest pain	☐Chronic cough	☐Chronic sinusitis
☐Colitis	☐Constipation	☐Convulsions	☐COPD	☐Depression
☐Dermatitis, Eczema/Rash	☐Diabetes	☐Difficulty in swallowing	☐Dizziness	☐Emphysema
☐Endometriosis	☐Epilepsy	☐Excessive thirst	☐Fainting	☐Frequent urination
☐General fatigue	☐Gout	☐Hand pain	☐Headache	☐Heart attack
☐Heart disease	☐Heartburn/Indigestion	☐Hepatitis	☐High Blood Pressure	☐High cholesterol
☐High PSA	☐High triglycerides	☐Hypertension	☐Irregular menstrual flow	☐Irritable colon
☐Jaw pain	☐Kidney disorders	☐Kidney stones	☐Liver/Gallbladder problems	☐Loss of appetite
☐Loss of bladder control	☐Low back pain	☐Lung Disease	☐Mental Disease	☐Mid back pain
☐Muscular in coordination	☐Neck pain	☐Osteoarthritis	☐Pain in ankle or foot	☐Pain in lower leg or knew
☐Pain in upper arm or elbow	☐Pain in upper leg and hip	☐Painful urination	☐PMS	☐Pneumonia
☐Profuse menstrual flow	☐Prostate problems	☐Rapid heart beat	☐Renal Disease	☐Theumatiod arthritis
☐Scoliosis	☐Shoulder pain	☐Stroke	☐Swelling/stiffness of joints	☐Thyroid disease
☐Tinnitus (ear noices)	☐Tuberculosis	☐Tumor	☐Ulcer	☐Visual disturbances
☐Wrist pain				

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Family History *Please select all conditions that run in your family:*

☐None	☐Other	☐Abdominal pain	☐Abnormal Weight gain/loss	☐Angina
☐Anorexia	☐Anxiety	☐Aortic aneurysm	☐Arthritis	☐Asthma
☐Bladder infection	☐Blood disorder	☐Brest lumps	☐Breast Soreness	☐Bronchitis
☐Cancer	☐Cardiovascular disease/heart attack	☐Chest pain	☐Chronic cough	☐Chronic sinusitis
☐Colitis	☐Constipation	☐Convulsions	☐COPD	☐Depression
☐Dermatitis, Eczema/Rash	☐Diabetes	☐Difficulty in swallowing	☐Dizziness	☐Emphysema
☐Endometriosis	☐Epilepsy	☐Excessive thirst	☐Fainting	☐Frequent urination
☐General fatigue	☐Gout	☐Hand pain	☐Headache	☐Heart attack
☐Heart disease	☐Heartburn/Indigestion	☐Hepatitis	☐High Blood Pressure	☐High cholesterol
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☐Pain in upper arm or elbow	☐Pain in upper leg and hip	☐Painful urination	☐PMS	☐Pneumonia
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☐Scoliosis	☐Shoulder pain	☐Stroke	☐Swelling/stiffness of joints	☐Thyroid disease
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☐Wrist pain				

Surgical History

Please select all surgeries that you have had in the past.

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty	☐ Abortion
☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty	☐ Appendectomy	☐ Bone Fracture Repair
☐ Breast Lump Removal	☐ Bunion Remova	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical spine Surgery
☐Cholecystectomy	☐ Cosmetic Breast Burgery	☐ C-Section	☐ Facelit	☐ Gallbladder Removal
☐ Gastric Bypass	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery	☐ Hernia Repair
☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant	☐ Knee Arthroscopy	☐ Knee Joint Replacement
☐ Knee surgery	☐ LASIK Eye Surgery	☐ Liposuction	☐ Lumbar spine surgery	☐ Mastectomy
☐ Prostate Removal	☐ Rotator Cuff Surgery	☐	☐ TMJ Surgery	☐ Tonsillectomy
☐ Vasectomy	☐ Surgical History was rev'd not contributory			

Medications *Please select all medications that you are currently taking:*

☐ None	☐ Other	☐ Advil
☐ Ambien	☐ Analgesics	☐ Anti-inflammatories
☐ Aspirin	☐ Atenolol	☐ Blood Pressure Medication
☐ Daily Vitamins	☐ Diabetes Medication	☐ Flexeril
☐ Isorsubrine	☐ Monopril	☐ Motrin
☐ Muscle relaxers	☐ Pin Medication	☐ Skelaxin
☐ Synthroid	☐ Tylenol	☐ Vicodin

Allergies *Please select all items that you are allergic to:*

☐ None	☐ Other	☐ Adhesive tape	☐ Animal dande	☐ Anticonvulsants
☐ Barbiturates	☐ Bee stings	☐ Dirt	☐ Dust mites	☐ Eggs
☐ Feathers	☐ Felt tip pens	☐ Fire ant stings	☐ Fish	☐ Gasoline fumes
☐ Hair Spray	☐ Histamine	☐ Hornet stings	☐ Insecticides	☐ Insulin
☐ Iodine	☐ Latex	☐ Milk	☐ Mold	☐Nail polish remover
☐ New Carpet	☐ Newspaper ink	☐ Paint or paint thinner	☐ Peanuts	☐ Penicillin
☐ Perfume	☐ Pets	☐ Pollen	☐ Pool Chlorine	☐ Seafood
☐ Shampoo	☐ Shellfish	☐ Smoke	☐ Soy	☐ Sulfa Drugs
☐ Tobacco smoke	☐ Tree nuts	☐ Wasp Stings	☐ Wheat	☐Yellow jacket stings

Social History *Please answer the following questions:*

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee