

-- Auto Accident Information --

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Please complete this packet as completely and as accurately as your current condition allows. Where response choices are required, please use a check mark "✓" to indicate the most appropriate answer. If a question does not apply to you, please write "N/A" (not applicable). If you are unsure about how to accurately answer a question, write a "?" next to it. Please PRINT all responses and ask for assistance if you have any questions.

Patient's Name: _____ Today's Date: _____ Date of Injury: _____
Age: _____ Date of Birth: _____ Gender: ☐ M ☐ F Marital Status: _____ SS#: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Mobile Phone: (____) _____ Email Address: _____
Emergency Contact Name: _____ Emergency Phone: (____) _____
Occupation: _____ Employer: _____
Employer's Address: _____ Work Phone: _____

At the time of the collision, who was driving the vehicle you were in? ☐ I was ☐ The person indicated below was driving:
(Do Not Complete This Section If *You* Were the Driver) Driver's Name: _____
Driver's Address: _____ Driver's Phone: (____) _____

Was the vehicle registered to you? ☐ Yes ☐ No If not, who was it registered to? _____
Your seating position in the vehicle: ☐ Front Seat ☐ Back Seat / ☐ Left ☐ Right ☐ Center _____
Was anyone else in the vehicle with you at the time of the collision? ☐ Yes ☐ No If yes, identify all persons below:

	Name	Relationship	Age	Injured?
1.	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
2.	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
3.	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
4.	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

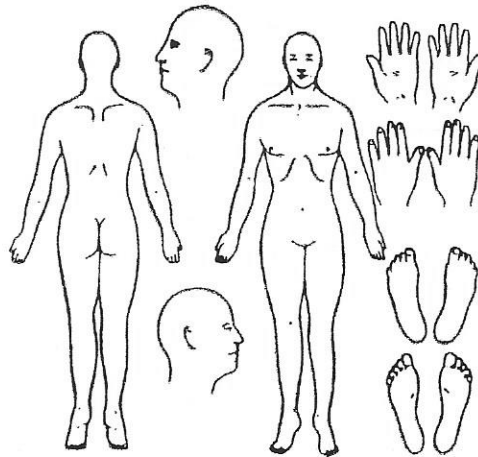
Were you on the job at the time of the collision? ☐ Yes ☐ No If yes, was it reported to your employer? ☐ Yes ☐ No
Location of the accident: _____
What were the road and weather conditions like at the time? _____
Please describe, in detail, how the accident happened: _____

Please diagram the accident below. Be sure to indicate which vehicle you were in. Feel free to use arrows and lines as needed

Total number of vehicles involved in the collision: _____
Total number of impacts to your vehicle: _____
Side(s) of your vehicle impacted: _____
Were you wearing a lap & shoulder belt? ☐ Yes ☐ No
Was there a head restraint? ☐ Yes ☐ No
At impact, was head forward of head restraint? ☐ Yes ☐ No
At impact, was your head rotated? ☐ Yes ☐ No
At impact, was your torso rotated? ☐ Yes ☐ No
At impact, was your body leaning forward? ☐ Yes ☐ No
Did you anticipate the impact? ☐ Yes ☐ No
Estimated speed of YOUR vehicle at impact: _____ mph
Estimated speed of OTHER vehicle at impact: _____ mph

Did you strike anything within the vehicle? ☐ Yes ☐ No If yes, please identify the item struck in the vehicle from the list below. Also, please draw a line from the item impacted to the part of the body struck.

- ☐ Airbag
- ☐ Dashboard
- ☐ Windshield
- ☐ Steering wheel
- ☐ Gear selector
- ☐ Head restraint
- ☐ Inner door panel
- ☐ Ceiling
- ☐ Armrest
- ☐ _____
- ☐ _____



Comments

Did the seat you were in break and/or fall backwards from the impact? ☐ Yes ☐ No Explain: _____

Did any windows break in your vehicle? ☐ Yes ☐ No If yes, please identify: _____

Was there any "flying" glass from the impact? ☐ Yes ☐ No If yes, please identify: _____

Were there any: Cuts? ☐ Yes ☐ No / Bruises? ☐ Yes ☐ No / Abrasions? ☐ Yes ☐ No / Photos taken? ☐ Yes ☐ No

If yes, please describe: _____

Make and model of the vehicle you were in: _____ Year: _____

Describe any damage done to the vehicle you were in: _____

Photos taken? ☐ Yes ☐ No

Make and model of the other vehicle(s): _____ Year: _____

Describe any damage done to the other vehicle(s): _____

Photos taken? ☐ Yes ☐ No

After impact, did you: lose consciousness at any time? ☐ Yes ☐ No _____

lose bowel or bladder control? ☐ Yes ☐ No _____

have facial numbness/speech problems? ☐ Yes ☐ No _____

extremity numbness/weakness? ☐ Yes ☐ No _____

Were you able to get out of the vehicle on your own? ☐ Yes ☐ No If not, who helped you? _____

If you were assisted out of your vehicle, describe how you were removed: _____

Did you receive any first aid at the scene? ☐ Yes ☐ No If yes, by whom? _____

If applicable, what first aid was provided to you at the scene? _____

Who was called or came to the accident scene? ☐ Highway Patrol ☐ Local Police ☐ Sheriff ☐ Paramedics

☐ Ambulance ☐ Other _____

Was a report made? ☐ Yes ☐ No If yes, do you have a copy? ☐ Yes ☐ No ☐ Not yet, but I will provide it.

Did you go to the emergency room? ☐ Yes ☐ No Urgent care? ☐ Yes ☐ No Doctor's office? ☐ Yes ☐ No
 If you answered "yes" to any of the above questions, please identify where you went and who attended you there: _____

What was done for you there? Exam: ☐ Yes ☐ No Pain medication: ☐ Yes ☐ No
 X-ray: ☐ Yes ☐ No Anti-inflammatories: ☐ Yes ☐ No
 MRI: ☐ Yes ☐ No Muscle relaxants: ☐ Yes ☐ No
 CT: ☐ Yes ☐ No Supports/Braces: ☐ Yes ☐ No

What diagnoses were you given? _____

Were you told to do anything by the attending doctor? ☐ Yes ☐ No If yes, please identify: _____

Were you hospitalized at any time as a result of the injuries you sustained from the accident? ☐ Yes ☐ No If yes, please identify the name and location of the hospital, entry date, exit date, and the name of the treating doctor(s): _____

What was done for you at the hospital? _____

Describe symptoms: Immediately after the accident: _____

 Later that same day: _____

 The next day: _____

Have you seen any other health care professional since the first day of the accident? ☐ Yes ☐ No If yes, please complete the section below: (Begin with the person you saw first and proceed to the most recent.)

Name	Title	Dates seen	What was done for you?
------	-------	------------	------------------------

Please identify any other treatment for this injury (check all that apply):

(specify)

<input type="checkbox"/> Heat	<input type="checkbox"/> Slept in different position	<input type="checkbox"/> Restricted home activities: _____
<input type="checkbox"/> Cold	<input type="checkbox"/> Slept on a different surface	_____
<input type="checkbox"/> Rest	<input type="checkbox"/> Minimized motions of the head	<input type="checkbox"/> Restricted work activities: _____
<input type="checkbox"/> Exercise	<input type="checkbox"/> Minimized overhead work	_____
<input type="checkbox"/> Stretches	<input type="checkbox"/> Minimized lifting	<input type="checkbox"/> Continued prescription meds: _____
<input type="checkbox"/> Massage	<input type="checkbox"/> Minimized sitting	<input type="checkbox"/> Took over-the-counter meds: _____
<input type="checkbox"/> Other: _____		

Normal job duties: _____

Current job duties: _____

Have you missed any work and/or job opportunities as a result of your auto accident? ☐ Yes ☐ No Please identify: _____

Have you had any injury or significant illness *since* the auto injury? ☐ Yes ☐ No If yes, please describe: _____

Have you had any significant injury or illness, of any type, *prior* to the auto injury? ☐ Yes ☐ No If yes, what was the nature of the problem and when did it occur? _____

If professional care was rendered for the above prior injury or condition, how long were you treated, by whom, and what was done for you? Was it fully resolved? _____

Have you ever had any award of permanent disability/impairment for any prior condition/injury? ☐ Yes ☐ No If yes, please identify what the award was, when it was received, and for what condition/injury: _____

Are you currently under any other doctor's care? ☐ Yes ☐ No If yes, who is the doctor and what is he/she treating you for? _____

What medications, prescribed or not, are you currently taking to treat any condition or injury *unrelated* to your auto accident injuries? _____

Have you ever served in the armed forces? ☐ Yes ☐ No If yes, what were the dates of service and what type of discharge did you receive? _____

Prior to this auto accident, have you ever been diagnosed as having any of the following? Circle *all* that apply.

Whiplash	Neck Sprain	Spondylolysis	Vertebral Fracture	Rheumatoid Arthritis
Scoliosis	Back Sprain	Facet Arthrosis	Metabolic Disorder	Ankylosing Spondylitis
Spondylosis	Osteoporosis	Disc Protrusion	Diabetes Type 1 or 2	Foraminal Encroachment
Fibromyalgia	Pagets Disease	Spinal Infection	Any Spinal Anomaly	Carpal Tunnel Syndrome
TMJ Problem	Spinal Stenosis	Spondylolisthesis	Extremity Dislocation	Degenerative Disc Disease

Comments: _____

Before the auto accident, how would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you currently use tobacco products? ☐ Yes ☐ No If yes, how much do you smoke per day? _____

Do you currently drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____

Did you have any recreational activities or hobbies before the accident? ☐ Yes ☐ No If yes, what were they and how often did you do them? _____

Please provide any additional information you believe is important to your case: _____

Current Medical Complaints

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It is important to carefully identify your current complaints. Use the body diagram to identify the location and nature of your symptoms. **Please use the key below.**

+++ = sharp or stabbing

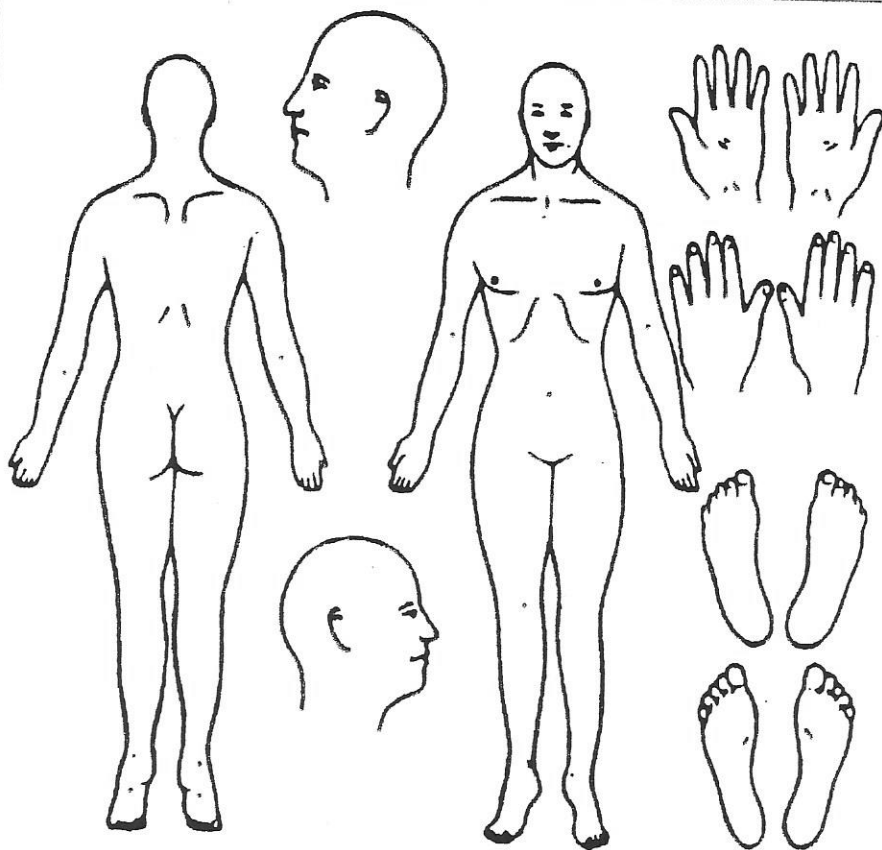
~ ~ ~ = burning

ooo = pins and needles

vvv = dull or aching

/// = numbness

-- Comments --



--- Circle the number of any and all symptoms that have appeared, even briefly, since the time of the auto collision. ---

1. Nausea
2. Vertigo/dizziness/lightheadedness
3. Neck pain/stiffness
4. Headache
5. Photophobia (sensitivity to light)
6. Phonophobia (sensitivity to loud noises)
7. Tinnitus (ringing in the ears)
8. Impaired memory
9. Difficulty concentrating
10. Impaired comprehension or awareness
11. Prolonged, unexplained staring
12. A feeling of having a "brain fog"
13. Forgetfulness
14. Impaired logical thinking
15. Difficulty with new or abstract concepts
16. Insomnia (difficulty sleeping)
17. Fatigue
18. Apathy
19. Outburst of anger
20. Mood swings
21. Depression
22. Loss of libido (sex drive)
23. Personality change
24. Intolerance to alcohol

25. Clicking in the jaw
26. Popping in the jaw
27. Locking of the jaw
28. Side shift of the jaw upon opening
29. Inability to open the mouth wide
30. Pain on chewing
31. Facial pain
32. Grinding your teeth
33. Jaw muscles sore upon waking
34. Chewing on one side of your mouth
35. Painful teeth
36. Loose or chipped teeth
37. Tender muscles in front of the neck

38. Pain on swallowing
39. Difficulty swallowing
40. Intolerance to strong odors
41. Decreased ability to smell
42. Decreased ability to taste
43. Vision changes

44. Blood in the urine
45. Pain over one or both kidneys
46. Urinary problems

47. Loss of weight
48. Weight gain
49. Nightmares
50. Pain on inhaling deeply
51. Indigestion
52. Diarrhea
53. Constipation
54. Vomiting
55. Nervousness
56. Cramping
57. Knees buckling unexpectedly
58. Dropping things easily
59. Weakness in the arms or legs

Other Symptoms and/or Comments:

Please sign and date this 5-page form here: Signature: _____ Date: _____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

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

- | | |
|---|--|
| <input type="checkbox"/> I go to work but work in pain | <input type="checkbox"/> I work in pain because I have bills to pay |
| <input type="checkbox"/> I limit my work activities | <input type="checkbox"/> I can't take time off because I would lose my job |
| <input type="checkbox"/> Bending at work hurts | <input type="checkbox"/> I keep working so I don't lose status at company |
| <input type="checkbox"/> Stooping at work hurts | <input type="checkbox"/> My business would fail if I took time off |
| <input type="checkbox"/> Sitting at work hurts | <input type="checkbox"/> I believe in working even when I'm in pain |
| <input type="checkbox"/> Using the Computer at work hurts | <input type="checkbox"/> I feel obligated to work even though I'm in pain |
| <input type="checkbox"/> Pushing at work hurts | <input type="checkbox"/> My business would lose money if I took time off |
| <input type="checkbox"/> Pulling at work hurts | <input type="checkbox"/> My work is not as good as it was before accident |
| <input type="checkbox"/> Kneeling at work hurts | <input type="checkbox"/> My boss reprimanded me for poor performance |
| <input type="checkbox"/> I have lost status in my company | <input type="checkbox"/> I got a different job within the same company |
| <input type="checkbox"/> I have lost job security | <input type="checkbox"/> I got a different job in another company |
| <input type="checkbox"/> I didn't get a promotion | <input type="checkbox"/> I make less money than before the accident |
| <input type="checkbox"/> I don't enjoy work as much as before | <input type="checkbox"/> I cannot do the same work/job as before accident |
| <input type="checkbox"/> I doze off at work | <input type="checkbox"/> I can't concentrate as well at work |
| <input type="checkbox"/> I take unpaid time off work to go to Dr. | <input type="checkbox"/> I take paid time off to go to Dr. |
| <input type="checkbox"/> I daydream at work more than before | <input type="checkbox"/> I make mistakes at work I didn't used to |
| <input type="checkbox"/> I feel tired at work | <input type="checkbox"/> I hide my poor work performance from my boss |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

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

- | | |
|---|--|
| <input type="checkbox"/> My house is not as clean now | <input type="checkbox"/> I cannot take time off because I care for children |
| <input type="checkbox"/> My yard is not as neat now | <input type="checkbox"/> I have _____ children ages _____ |
| <input type="checkbox"/> My garden is not as productive now | <input type="checkbox"/> I had to hire a paid housekeeper |
| <input type="checkbox"/> I do yard work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid housekeeping help |
| <input type="checkbox"/> I cannot do my normal yard work | <input type="checkbox"/> I had to hire a paid gardener |
| <input type="checkbox"/> I do house work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid yard work help |
| <input type="checkbox"/> I cannot do my normal house work | <input type="checkbox"/> Mowing the lawn hurts me |
| <input type="checkbox"/> Doing laundry hurts me | <input type="checkbox"/> I cannot mow the lawn |
| <input type="checkbox"/> I cannot do laundry now | <input type="checkbox"/> Taking out the trash hurts me |
| <input type="checkbox"/> Washing dishes hurts me | <input type="checkbox"/> I cannot take out the trash |
| <input type="checkbox"/> I cannot wash dishes now | <input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to |
| <input type="checkbox"/> Vacuuming hurts me | <input type="checkbox"/> I do not enjoy my housework like I used to |
| <input type="checkbox"/> I cannot vacuum now | <input type="checkbox"/> Gardening hurts me |
| <input type="checkbox"/> Cooking hurts me | <input type="checkbox"/> I cannot do my gardening at all since the accident |
| <input type="checkbox"/> I cannot cook now | <input type="checkbox"/> Others living with me do my share of the work now |
| <input type="checkbox"/> Washing the car hurts me | <input type="checkbox"/> Others living with me do my share of the yard work |
| <input type="checkbox"/> I cannot wash my car | <input type="checkbox"/> Others living with me do my share of the gardening |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Signature _____

Date _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> My exercise was affected by this crash | <input type="checkbox"/> I have gained _____ pounds since the accident |
| <input type="checkbox"/> I go to the gym & work out in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I no longer go to the gym to work out | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I run but in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I no longer run | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I take walks & have pain while walking | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I no longer take walks | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I used to make income at sports | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I have lost sports income since crash | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I am an amateur athlete | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I am a professional athlete | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |

Please check all that apply to your HOBBY Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> My hobbies were affected by accident | <input type="checkbox"/> Hobby #3 _____ |
| <input type="checkbox"/> Hobby #1 _____ | <input type="checkbox"/> I can't do hobby #3 anymore |
| <input type="checkbox"/> I can't do hobby #1 anymore | <input type="checkbox"/> I do hobby #3 but in pain |
| <input type="checkbox"/> I do hobby #1 but in pain | <input type="checkbox"/> I have lost money from not doing #3 |
| <input type="checkbox"/> I have lost money from not doing #1 | <input type="checkbox"/> I didn't do hobby #3 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #1 for _____ weeks | <input type="checkbox"/> Hobby #4 _____ |
| <input type="checkbox"/> Hobby #2 _____ | <input type="checkbox"/> I can't do hobby #4 anymore |
| <input type="checkbox"/> I can't do hobby #2 anymore | <input type="checkbox"/> I do hobby #4 but in pain |
| <input type="checkbox"/> I do hobby #2 but in pain | <input type="checkbox"/> I have lost money from not doing #4 |
| <input type="checkbox"/> I have lost money from not doing #2 | <input type="checkbox"/> I didn't do hobby #4 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #2 for _____ weeks | <input type="checkbox"/> _____ |

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

- | | |
|---|--|
| <input type="checkbox"/> Business travel was affected by crash | <input type="checkbox"/> Travel Plan #1 _____ |
| <input type="checkbox"/> Pleasure travel was affected by crash | <input type="checkbox"/> I did not go on travel plan #1 |
| <input type="checkbox"/> I hurt driving in my own car | <input type="checkbox"/> I went, but did not enjoy #1 as much |
| <input type="checkbox"/> I am in too much pain to drive | <input type="checkbox"/> I went and the accident had no effect on #1 |
| <input type="checkbox"/> I hurt when a passenger in a car | <input type="checkbox"/> Travel Plan #2 _____ |
| <input type="checkbox"/> I am in too much pain to sit in a car | <input type="checkbox"/> I did not go on travel plan #2 |
| <input type="checkbox"/> I have anxiety when I'm in a car | <input type="checkbox"/> I went, but did not enjoy #2 as much |
| <input type="checkbox"/> I hurt when I'm on an airplane | <input type="checkbox"/> I went and the accident had no effect on #2 |
| <input type="checkbox"/> I am in too much pain to travel by plane | <input type="checkbox"/> I missed time with my family/friends b/c can't travel |