INITIAL EVALUATION – Automobile Accident

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

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

When did this accident happen? _____

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?

☐ I hit another vehicle ☐ Another vehicle hit me ☐ I hit an 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

What is the position of the headrest: ☐ Even with top of my head
☐ Even with bottom of my head
☐ Middle of neck

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

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What inside your vehicle did you strike?

□ Airbag	□ Armrest	□ Center Console	□ Dashboard	□ Gear shift lever/knob
□ Headrest	□ Rearview mirror	□ Roof	□ Rear window	□ Seatback
□ Side door	□ Side window	□ Wheel	□ Windshield	
□ Other:_____				

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 Pain ☐ 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

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	□ Weight gain/loss	□ Angina
□ Anorexia	□ Anxiety	□ Aortic aneurysm	□ Arthritis	□ Asthma
□ Bladder infection	□ Blood disorder	□ Breast lumps	□ Breast soreness	□ Bronchitis
□ Cancer	□ Cardiovascular Dx	□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 knee
□ Pain in upper arm or elbow	□Pain in upper leg and hip	□ Painful urination	□ PMS	□ Pneumonia
□ Profuse menstrual flow	□Prostate problems	□ Rapid heartbeat	□ Renal disease	□Rheumatiod arthritis
□Scoliosis	□Shoulder pain	□Stroke	□ Swelling/stiffness joints	□Thyroid disease of
□Tinnitus/ ear noises	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	□ Weight Gain/loss	□ Angina
□ Anorexia	□ Anxiety	□ Aortic aneurysm	□ Arthritis	□ Asthma
□ Bladder infection	□ Blood disorder	□ Breast lumps	□ Breast soreness	□ Bronchitis
□ Cancer	□ Cardiovascular Dx	□ Chest pain	□ Chronic cough	□ Chronic Sinusitis
□ Colitis	□ Constipation	□ Convulsions	□ COPD	□ Depression
□ Dermatitis, Eczema/Rash	□ Diabetes	□ Difficulty swallowing	□ Dizziness	□ Emphysema
□ Endometriosis	□ Epilepsy	□ Excessive thirst	□ Fainting	□ Frequent urination
□ General fatigue	□ Gout	□ Hand pain	□ Headache	□ Heart attack
□ Heart disease	□ Heartburn/Indigestion	□ Hepatitis	□ HBP	□ 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 coordination	□ Neck pain	□ Osteoarthritis	□ Pain in ankle or foot	□ Pain in lower leg or knee
□ Pain in upper arm or elbow	□ Pain in upper leg and hip	□ Painful urination	□ PMS	□ Pneumonia
□ Profuse menstrual flow	□ Prostate problems	□ Rapid heartbeat	□ Renal Dx	□ Rheumatoid arthritis
□ Scoliosis	□ Shoulder pain	□ Stroke	□ Swelling/stiffness of joints	□ Thyroid disease
□ Tinnitus/ ear noises	□ Tuberculosis	□ Tumor	□ Ulcer	□ Visual disturbances
	□ Wrist pain			

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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 Removal	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery
☐ Cholecystectomy	☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ 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 reviewed:
Not contributory

Medications

Please select all medications that you are currently taking:

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	
☐ OTC	☐ Pain	☐ Steroids	☐ Thyroid	

Allergies

Please select all items that you are allergic to:

☐ None	☐ Chemical	☐ Environmental	
☐ Food	☐ Medication	☐ Seasonal	☐ Other

Social History

Please answer the following

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

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

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee