

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 |

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☐ 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 | ☐ Rheumatoid 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