Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

❑ Car ❑ Station Wagon
❑ Van ❑ Pickup Truck
❑ Large Truck ❑ Bus
❑ Other _____

2. Your position in vehicle

❑ Driver ❑ Front Passenger
❑ Left Rear Passenger
❑ Right Rear Passenger
❑ Other _____

3. What was your vehicle doing at the time of the accident?

❑ Stopped at intersection ❑ Stopped in Traffic ❑ Stopped at light
❑ Making a right turn ❑ Making a left turn ❑ Parking
❑ Proceeding along ❑ Slowing down ❑ Accelerating
❑ Other _____

4. Time/Speed/Damage

Time of accident _____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
❑ Mid ❑ Moderate
❑ Totaled

5. Details of Accident

Visibility at time of accident
❑ Poor ❑ Fair ❑ Good
Who hit who/what
❑ You hit other vehicle
❑ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry

Point of impact
❑ Head-On ❑ Left Front ❑ Right Front
❑ Rear-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

Did you see the accident coming: Yes ❑ ❑ No
Were you braced for the impact? Yes ❑ ❑ No
Did you have a seat belt on? Yes ❑ ❑ No
Did you have a shoulder harness on? Yes ❑ ❑ No

Does your vehicle have headrests? Yes ❑ ❑ No
What was the position of your headrest at the time of impact?
❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
What was the direction of your head at the time of impact?
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side airbags deploy? Yes ❑ ❑ No Did passenger side airbags deploy? Yes ❑ ❑ No Did side airbags deploy? Yes ❑ ❑ No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident

Did your body strike the inside of the vehicle? Yes ❑ ❑ No
If yes, describe: _____
Did you lose consciousness during the injury? Yes ❑ ❑ No
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled
Did police show up at the scene? Yes ❑ ❑ No
Was an accident report filled out? Yes ❑ ❑ No

10. After the accident

Check off your symptoms right after and a few days following:

❑ Headache	❑ Dizziness	❑ Mid back pain	❑ Cold hands
❑ Neck pain	❑ Nausea	❑ Low back pain	❑ Cold feet
❑ Neck Stiffness	❑ Confusion	❑ Nervousness	❑ Diarrhea
❑ Fainting	❑ Fatigue	❑ Loss of taste	❑ Depression
❑ Ringing in ears	❑ Tension	❑ Toe numbness	❑ Anxious
❑ Loss of smell	❑ Irritability	❑ Constipation	❑ Chest pain

❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping Problems
Others: _____

11. Emergency Room?

Where did you go after the accident?
❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor
How did you get there?
❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police
Where X-rays done? Yes ❑ ❑ No Was lab work done? Yes ❑ ❑ No
Body parts X-rayed? _____
What lab work? _____
The X-Rays revealed? _____
Treatments? ❑ Cervical Collar ❑ Ice Other: _____
Medications: _____
Follow-up instructions: _____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty: _____ X-rays done? Yes ❑ ❑ No
Types of treatments received? _____
Did treatments benefit you? Yes ❑ ❑ No
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Specialty: _____ X-rays done? Yes ❑ ❑ No
Types of treatments received? _____
Did treatments benefit you? Yes ❑ ❑ No
Last visit date: ____/____/____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section.

1. Check only one body location below

❑ Headaches	❑ L	❑ R	❑ B
	❑ Front of Head		
	❑ Top of Head		
	❑ Back of Head		
❑ Jaw	❑ L	❑ R	❑ B
❑ Eye	❑ L	❑ R	❑ B
❑ Neck	❑ L	❑ R	❑ B
❑ Upper Back	❑ L	❑ R	❑ B
❑ Mid Back	❑ L	❑ R	❑ B
❑ Low Back	❑ L	❑ R	❑ B
❑ Chest	❑ L	❑ R	❑ B
❑ Abdomen	❑ L	❑ R	❑ B
❑ Ribs	❑ L	❑ R	❑ B
❑ Buttocks	❑ L	❑ R	❑ B
❑ Shoulder	❑ L	❑ R	❑ B
❑ Upper Arm	❑ L	❑ R	❑ B
❑ Forearm	❑ L	❑ R	❑ B
❑ Hand	❑ L	❑ R	❑ B
❑ Lip	❑ L	❑ R	❑ B
❑ Leg	❑ L	❑ R	❑ B
❑ Foot	❑ L	❑ R	❑ B
❑ Other_____			

2. Types of Pain Other types of pain:

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting

❑ Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping _____

❑ Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑ Constricting _____

3. Pain Frequency

❑ Up to 1/4 of awake time ❑ 1/4 to 1/2 of the time

❑ 1/2 to 3/4 of awake time ❑ Most all the time

4. Pain intensity (How if affects your daily activities

❑ Doesn't affect ❑ Somewhat affects

❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
❑ Other Actions:			
_____	❑	❑	❑

II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

1. Check only one body location below

❑ Headaches	❑ L	❑ R	❑ B
	❑ Front of Head		
	❑ Top of Head		
	❑ Back of Head		
❑ Jaw	❑ L	❑ R	❑ B
❑ Eye	❑ L	❑ R	❑ B
❑ Neck	❑ L	❑ R	❑ B
❑ Upper Back	❑ L	❑ R	❑ B
❑ Mid Back	❑ L	❑ R	❑ B
❑ Low Back	❑ L	❑ R	❑ B
❑ Chest	❑ L	❑ R	❑ B
❑ Abdomen	❑ L	❑ R	❑ B
❑ Ribs	❑ L	❑ R	❑ B
❑ Buttocks	❑ L	❑ R	❑ B
❑ Shoulder	❑ L	❑ R	❑ B
❑ Upper Arm	❑ L	❑ R	❑ B
❑ Forearm	❑ L	❑ R	❑ B
❑ Hand	❑ L	❑ R	❑ B
❑ Lip	❑ L	❑ R	❑ B
❑ Leg	❑ L	❑ R	❑ B
❑ Foot	❑ L	❑ R	❑ B
❑ Other_____			

2. Types of Pain Other types of pain:

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting

❑ Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping _____

❑ Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑ Constricting _____

3. Pain Frequency

❑ Up to 1/4 of awake time ❑ 1/4 to 1/2 of the time

❑ 1/2 to 3/4 of awake time ❑ Most all the time

4. Pain intensity (How if affects your daily activities

❑ Doesn't affect ❑ Somewhat affects

❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
❑ Other Actions:			
_____	❑	❑	❑

III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below

❑ Headaches	❑ L	❑ R	❑ B
	❑ Front of Head		
	❑ Top of Head		
	❑ Back of Head		
❑ Jaw	❑ L	❑ R	❑ B
❑ Eye	❑ L	❑ R	❑ B
❑ Neck	❑ L	❑ R	❑ B
❑ Upper Back	❑ L	❑ R	❑ B
❑ Mid Back	❑ L	❑ R	❑ B
❑ Low Back	❑ L	❑ R	❑ B
❑ Chest	❑ L	❑ R	❑ B
❑ Abdomen	❑ L	❑ R	❑ B
❑ Ribs	❑ L	❑ R	❑ B
❑ Buttocks	❑ L	❑ R	❑ B
❑ Shoulder	❑ L	❑ R	❑ B
❑ Upper Arm	❑ L	❑ R	❑ B
❑ Forearm	❑ L	❑ R	❑ B
❑ Hand	❑ L	❑ R	❑ B
❑ Lip	❑ L	❑ R	❑ B
❑ Leg	❑ L	❑ R	❑ B
❑ Foot	❑ L	❑ R	❑ B
❑ Other_____			

2. Types of Pain Other types of pain:

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting

❑ Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping _____

❑ Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑ Constricting _____

3. Pain Frequency

❑ Up to 1/4 of awake time ❑ 1/4 to 1/2 of the time

❑ 1/2 to 3/4 of awake time ❑ Most all the time

4. Pain intensity (How if affects your daily activities

❑ Doesn't affect ❑ Somewhat affects

❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
❑ Other Actions:			
_____	❑	❑	❑

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most describes your current degree of difficulty: **1** = "I can do it without any difficulty", 2 = "I can do it without much difficulty, despite some pain, **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain. **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ___	Drying hair ___	Brushing teeth ___	Putting on shoes ___	Preparing meals ___	Leaning back ___
Showering ___	Combing hair ___	Making bed ___	Tying shoes ___	Eating ___	Doing laundry ___
Washing hair ___	Washing face ___	Putting on shirt ___	Putting on pants ___	Cleaning dishes ___	Going to toilet ___

Difficulties with Physical Activities

Standing ___	Walking ___	Kneeling ___	Bending back ___	Twisting left ___	Leaning back ___
Sitting ___	Stooping ___	Reaching ___	Bending left ___	Twisting right ___	Leaning left ___
Reclining ___	Squatting ___	Bending forward ___	Bending right ___	Leaning forward ___	Leaning right ___
Standing for long periods ___	Sitting for long periods ___		Walking for long periods ___	Kneeling for long periods ___	

Difficulties with Functional Activities

Carrying small objects ___	Lifting weights off floor ___	Pushing things while seated ___	Exercising upper body ___
Carrying large objects ___	Lifting weight off table ___	Pushing things while standing ___	Exercising lower body ___
Carrying briefcase ___	Climbing stairs ___	Pulling things while seated ___	Exercising arms ___
Carrying large purse ___	Climbing inclines ___	Pulling things while standing ___	Exercising legs ___

Difficulties with Social and Recreational Activities

Bowling ___	Jogging ___	Swimming ___	Ice Skating ___	Competitive Sports ___	Dating ___
Golfing ___	Dancing ___	Skiing ___	Roller Skating ___	Hobbies ___	Dining Out ___

Difficulties with Traveling

Driving a motor vehicle ___	Riding as a passenger in a motor vehicle ___	Riding as a passenger on a train ___
Driving for long periods of time ___	Riding as a passenger in an airplane ___	Riding as a passenger for long periods ___

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = "My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating ___	Hearing ___	Listening ___	Speaking ___	Reading ___	Writing ___	Using keyboard ___

Difficulties with the senses

Seeing ___	Hearing ___	Sense of touch ___	Sense of taste ___	Sense of smell ___

Difficulties with Hand Functions

Grasping ___	Holding ___	Pinching ___	Percussive movements ___	Sensory Discrimination ___

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep ___ Being able to participate in desired sexual activity ___

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above)

Prior Symptom History

Prior Similar Symptoms	**Has your History Contributed to your Current Symptoms?**
❑ I have NOT had prior symptoms to my current complaints	❑ My history HAS contributed to my current symptoms.
❑ My current complaints DID exist before, but have not been bothering me.	❑ My history HAS NOT contributed to my current symptoms.
❑ My current complaints ALREADY existed and were worsened.	❑ I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior symptoms **(if applicable)** occurred....._____ ❑ months ago / ❑ years ago Or on Date:_____/_____/_____

Write in below any other Prior Symptom History, not covered above: