

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. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"> 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 ☐ </td> <td style="width: 33%;"> 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 </td> <td style="width: 33%;"></td> </tr> </table> Did driver side airbags deploy? Yes ☐ No ☐ Did passenger side airbags deploy? Yes ☐ No ☐ Did side airbags deploy? Yes ☐ No ☐			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																										
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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: <table style="width: 100%;"> <tr> <td>☐ Headache</td> <td>☐ Dizziness</td> <td>☐ Mid back pain</td> <td>☐ Cold hands</td> </tr> <tr> <td>☐ Neck pain</td> <td>☐ Nausea</td> <td>☐ Low back pain</td> <td>☐ Cold feet</td> </tr> <tr> <td>☐ Neck Stiffness</td> <td>☐ Confusion</td> <td>☐ Nervousness</td> <td>☐ Diarrhea</td> </tr> <tr> <td>☐ Fainting</td> <td>☐ Fatigue</td> <td>☐ Loss of taste</td> <td>☐ Depression</td> </tr> <tr> <td>☐ Ringing in ears</td> <td>☐ Tension</td> <td>☐ Toe numbness</td> <td>☐ Anxious</td> </tr> <tr> <td>☐ Loss of smell</td> <td>☐ Irritability</td> <td>☐ Constipation</td> <td>☐ Chest pain</td> </tr> <tr> <td>☐ Pain behind eyes</td> <td>☐ Shortness of breath</td> <td>☐ Sleeping Problems</td> <td></td> </tr> </table> Others: _____		☐ 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	
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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 it affects your daily activities) ☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Prevents activities 5. Does this pain radiate into other body parts? <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Left</th> <th style="text-align: center;">Right</th> <th style="text-align: center;">Both</th> </tr> </thead> <tbody> <tr><td>☐ Head</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Neck</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Shoulder</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Arm</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Hand</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Hip</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Leg</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Foot</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> </tbody> </table> Other locations of radiation: _____		Left	Right	Both	☐ Head	☐	☐	☐	☐ Neck	☐	☐	☐	☐ Shoulder	☐	☐	☐	☐ Arm	☐	☐	☐	☐ Hand	☐	☐	☐	☐ Hip	☐	☐	☐	☐ Leg	☐	☐	☐	☐ Foot	☐	☐	☐																												
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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 it affects your daily activities) ☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Prevents activities 5. Does this pain radiate into other body parts? <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Left</th> <th style="text-align: center;">Right</th> <th style="text-align: center;">Both</th> </tr> </thead> <tbody> <tr><td>☐ Head</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Neck</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Shoulder</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Arm</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Hand</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Hip</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Leg</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> <tr><td>☐ Foot</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td><td style="text-align: center;">☐</td></tr> </tbody> </table> Other locations of radiation: _____		Left	Right	Both	☐ Head	☐	☐	☐	☐ Neck	☐	☐	☐	☐ Shoulder	☐	☐	☐	☐ Arm	☐	☐	☐	☐ Hand	☐	☐	☐	☐ Hip	☐	☐	☐	☐ Leg	☐	☐	☐	☐ Foot	☐	☐	☐																												
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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

- ☐ I have NOT had prior symptoms to my current complaints
☐ My current complaints DID exist before, but have not been bothering me.
☐ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ☐ My history HAS contributed to my current symptoms.
☐ My history HAS NOT contributed to my current symptoms.
☐ 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: