INITIAL EVALUATION – Work Related Automobile Accident

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

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

When did this accident happened? _____

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?

☐ You hit another vehicle ☐ Another vehicle hit you ☐ You hit another 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
If yes, positioned: ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

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

What inside your vehicle id you strike? ☐ Wheel ☐ Windshield ☐ Arm rest ☐ Dashboard
☐ Side Door ☐ Side window ☐ Airbag

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 Paid ☐ 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	□Abnormal Weight gain/loss	□Angina
□Anorexia	□Anxiety	□Aortic aneurysm	□Arthritis	□Asthma
□Bladder infection	□Blood disorder	□Brest lumps	□Breast Soreness	□Bronchitis
□Cancer	□Cardiovascular disease/heart attack	□Chest pain	□Chronic cough	□Chronic sinusitis
□Colitis	□Constipation	□Convulsions	□COPD	□Depression
□Dermatitis	□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	□High Blood Pressure	□High cholesterol
□High PSA	□High triglycerides	□Hypertension	□Irregular menstrual	□Irritable colon
□Jaw pain	□Kidney disorders	□Kidney stones	□Liver 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 knew
□Pain in upper arm or elbow	□Pain in upper leg and hip	□Painful urination	□PMS	□Pneumonia
□Profuse menstrual flow	□Prostate problems	□Rapid heart beat	□Renal Disease	□Theumatiod arthritis
□Scoliosis	□Shoulder pain	□Stroke	□Swelling/stiffness of joints	□Thyroid disease
□Tinnitus (ear noices)	□Tuberculosis	□Tumor	□Ulcer	□Visual disturbances
□Wrist pain	□**Gallbladder Problems**			

Family History *Please select all conditions that run in your family:*

□None	□Other	□Abdominal pain	□Abnormal Weight gain/loss	□Angina
□Anorexia	□Anxiety	□Aortic aneurysm	□Arthritis	□Asthma
□Bladder infection	□Blood disorder	□Brest lumps	□Breast Soreness	□Bronchitis
□Cancer	□Cardiovascular disease/heart attack	□Chest pain	□Chronic cough	□Chronic sinusitis
□Colitis	□Constipation	□Convulsions	□COPD	□Depression
□Dermatitis	□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	□High Blood Pressure	□High cholesterol
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□Scoliosis	□Shoulder pain	□Stroke	□Swelling/stiffness of joints	□Thyroid disease
□Tinnitus (ear noices)	□Tuberculosis	□Tumor	□Ulcer	□Visual disturbances
□Wrist pain	Gallbladder problems			

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 Remova
□ Carotid Artery Surgery
□ Cataract Surgery
□ Cervical spine Surgery
□Cholecystectomy
□ Cosmetic Breast Burgery
□ C-Section
□ Facelit
□ 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
□ Vasectomy
□ TMJ Surgery
□ Tonsillectomy
□ Surgical History was rev'd not contributory

Medications *Please select all medications that you are currently taking:*

□ None
□ Other
□ Advil
□ Ambien
□ Analgesics
□ Anti-inflammatories
□ Aspirin
□ Atenolol
□ Blood Pressure Medication
□ Daily Vitamins
□ Diabetes Medication
□ Flexeril
□ Isorsubrine
□ Monopril
□ Motrin
□ Muscle relaxers
□ Pin Medication
□ Skelaxin
□ Synthroid
□ Tylenol
□ Vicodin

Allergies *Please select all items that you are allergic to:*

□ None	□ Other	□ Adhesive tape	□ Animal dande	□ Anticonvulsants
□ Barbiturates	□ Bee stings	□ Dirt	□ Dust mites	□ Eggs
□ Feathers	□ Felt tip pens	□ Fire ant stings	□ Fish	□ Gasoline fumes
□ Hair Spray	□ Histamine	□ Hornet stings	□ Insecticides	□ Insulin
□ Iodine	□ Latex	□ Milk	□ Mold	□Nail polish remover
□ New Carpet	□ Newspaper ink	□ Paint or paint thinner	□ Peanuts	□ Penicillin
□ Perfume	□ Pets	□ Pollen	□ Pool Chlorine	□ Seafood
□ Shampoo	□ Shellfish	□ Smoke	□ Soy	□ Sulfa Drugs
□ Tobacco smoke	□ Tree nuts	□ Wasp Stings	□ Wheat	□Yellow jacket stings

Social History *Please answer the following questions:*

□ Married □ Single □ Widowed □ Divorced □ Separated

Do you have any children? If yes, how many? _____

Do you use: □ Tobacco □ Alcohol □ Coffee