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 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?

☐ You hit another vehicle ☐ Another vehicle hit you ☐ You hit another object

What was the point of impact on your 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 did 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 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	□Abnormal weight gain/loss	□Angina
□Anorexia	□Anxiety	□Aortic aneurysm	□Arthritis	□Asthma
□Bladder infection	□Blood disorder	□Breast lumps	□Breast soreness	□Bronchitis
□Cancer	□Cardiovascular disease	□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 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 of joints	□Thyroid disease
□Tinnitus/ ear noises	□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	□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
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□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 disease	□Rheumatoid arthritis
□Scoliosis	□Shoulder pain	□Stroke	□Swelling/stiffness of joints	□Thyroid disease
□Tinnitus/ ear noises	□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 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	□ Vasectomy	□ TMJ Surgery	□ Tonsillectomy
	□ Surgical History was rev'd not contributory			

Medications

Please select all medications that you are currently taking:

□ None	□ Other	□ Analgesics	□ Antacids	□ Anti-inflammatory
□ 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 questions:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

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

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee