Auto Accident Check In

NEW PATIENTS

Patient Name _____ Date of birth _____ today's date _____

Height _____ Weight _____ left or right handed ___

Date of accident: _____ Cell Phone _____

Attorney name: _____ Referred By: _____

Auto Accident details:

Please circle all that apply

Patient was: Restrained not restrained

Patient was: Driver front seat passenger back seat passenger

Please indicate type of vehicle and speed of vehicle for each involved:

Vehicle # 1(patient) type vehicle _____ speed _____mph

Vehicle # 2 type vehicle _____ speed _____mph

Vehicle # 3 type vehicle _____ speed _____mph

Vehicle # 4 type vehicle _____ speed _____mph

Location of accident _____

Patient's car was: Rear-ended t-boned on right t-boned on left struck head on

Other vehicle ran light or stop sign other _____

Did air bags deploy? Yes/No

Injury to head: YES/No

Loss of consciousness: Yes/No First recollection after loss of consciousness _____

Did patient strike any other body part? Yes/No If yes, please describe:

_____

_____

Symptoms at the scene of accident: _____

Evaluated by Emergency personnel at the accident scene: Yes/No

Transported by Emergency personnel: Yes/No

Transported by other means: Yes/No

Transported to: _____

X-rays/MRI/Diagnostic testing: _____

Meds given in ER: N-SAIDS Pain Medication Muscle relaxer

Name of medications _____

Follow up care: PCP Chiropractic Physical therapy

Name of physician: _____

Details of other accidents: any other accidents, slip and fall, work comp, etc.

_____
_____
_____
_____
_____

Status of prior injuries: resolved permanent chronic

Today's injuries/symptoms:

Neck Injury: new or aggravated no pain 1 2 3 4 5 6 7 8 9 10 extreme pain

Please circle if applicable: Pain numbness tingling burning

Nature of pain: stabbing nagging constant intermittent throbbing aching varies with activity Sporadic

_____

Mid-back: new or aggravated no pain 1 2 3 4 5 6 7 8 9 10 extreme pain

Please circle if applicable: Pain numbness tingling burning

Nature of pain: stabbing nagging constant intermittent throbbing aching varies with activity Sporadic

_____

Low-back: new or aggravated no pain 1 2 3 4 5 6 7 8 9 10 extreme pain

Please circle if applicable: Pain numbness tingling burning

Nature of pain: stabbing nagging constant intermittent throbbing aching varies with activity Sporadic

_____

Headache: new or aggravated no pain 1 2 3 4 5 6 7 8 9 10 extreme pain

Please circle if applicable: Pain numbness tingling burning

Headache pain location: front side back

Nature of pain: stabbing nagging constant intermittent throbbing aching varies with activity Sporadic

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Extremity involvement: Circle all that apply:

Left arm

Pain numbness tingling burning no symptoms area of arm _____

Right arm

Pain numbness tingling burning no symptoms area of arm _____

Left leg

Pain numbness tingling burning no symptoms area of leg _____

Right leg

Pain numbness tingling burning no symptoms area of leg _____

Misc. changes: **please circle any changes that occurred after your accident:**

Memory concentration Dizziness Balance Blurry vision Jaw pain

Ringing in ears nausea speech smell swallowing increased anxiety

Increased Depression difficulty walking

Current treatment: Physical Therapy Yes/No Pain Management Yes/No

Chiropractor Yes/No Neuropsych Yes/No

Neurosurgery Yes/No

Dates of treatment or surgery _____