

What was the date of your accident?

Circle if you were the: Driver Front seat passenger Rear seat passenger

Were you wearing your seat belt? Yes/no

Did the airbags deploy? Yes/no

Circle where your vehicle impacted: Rear Front Driver's side Passenger's side

Circle at the time of impact was your vehicle: Moving Stopped

Circle if your vehicle impacted any other objects: Tree Guardrail Light pole Other

What were you feeling IMMEDIATELY AFTER the accident?

Did you lose consciousness: Yes/no

If so how long were you unconscious?

When did you start to notice pain?_____ Where was it located?_____

Did you go the emergency room: Yes/no Which one?_____

When did you first receive medical care after the accident?_____

List the doctors you have seen in the order you have seen them and their specialty?

What type of treatments did they provide and how long did you receive it?

Medication:

Physical Therapy:

Chiropractic care:

Acupuncture:

Massage:

Traction:

Injections in the office:

Epidurals:

Surgery:

Other:

If you received physical therapy, acupuncture or chiropractic treatment, circle how many times a week you attended: Once Twice Three Four Five

Are you presently receiving treatment? Yes/no

Did you have Xrays? Yes/no

If so circle the body parts they imaged: Neck Back Shoulder Elbow Wrist/Hands Hips
Knees Ankles/Feet Head Other

What were the findings of the images?

Did you have CAT scans? Yes/no

If so circle the body parts they imaged: Neck Back Shoulder Elbow Wrist/Hands Hips
Knees Ankles/Feet Head Other

What were the findings of the images?

Did you have MRI's? Yes/no

If so circle the body parts they imaged: Neck Back Shoulder Elbow Wrist/Hands Hips
Knees Ankles/Feet Head Other

What were the findings of the images?

Did you have an EMG (nerve test with electricity and needles)? Yes/no

Did they perform the EMG on the: Neck and Arms? Back and Legs? Or Both?

Circle were the results of the EMG: Normal Abnormal

Did your doctors perform any other testing on you? Yes/no If so what?

Please list your symptoms starting with what bothers you the most and end with what bothers you the least:

On a scale of 1 to 10 (1 being a little pain and 10 being the most pain) rate the pain you are feeling presently:

Head	1	2	3	4	5	6	7	8	9	10
Neck	1	2	3	4	5	6	7	8	9	10
Shoulders	1	2	3	4	5	6	7	8	9	10
Arms	1	2	3	4	5	6	7	8	9	10
Mid back	1	2	3	4	5	6	7	8	9	10
Low back	1	2	3	4	5	6	7	8	9	10
Legs	1	2	3	4	5	6	7	8	9	10

Do you have weakness? Yes/no If so, where is weakness?

Do you have numbness? Yes/no If so, where is the numbness?

Do you have any bowel or bladder problems? Yes/no

Do you have fever or chills? Yes/no

What are your doctors recommending for your ongoing care?

What is your job?

Did you miss any time from work? Yes/no

Did you stop working as a result of the accident? Yes/no

Circle any medical problems: Diabetes, High blood pressure, Heart problems, Lung problems, Asthma, High cholesterol, Hyperthyroid, Hypothyroid, Ulcers, Kidney problems, Depression, Stroke, Neurologic problems, Vascular problems, Infectious diseases, Other.

Have you had any surgery? Yes/no If so, what?

Do you have any allergies to medications? Yes/no If so, to what medications?

What medications are you presently taking?

Did you EVER have a previous motor vehicle accident, fall or other trauma? Yes/no

If so when? _____ and what body parts did you injure?