



### INITIAL EVALUATION – Automobile Accident

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ Date: \_\_\_\_\_

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What brings you into our office?  **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

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- 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

## INITIAL EVALUATION – Automobile Accident

### Activities of Daily Living

*Please select all activities which you are currently experiencing problems:*

- |                                    |  |                                     |                                     |                                    |   |
|------------------------------------|--|-------------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Seeing    | <input type="checkbox"/> Tasting       | <input type="checkbox"/> Smelling   | <input type="checkbox"/> Eating     | <input type="checkbox"/> Hearing   | <input type="checkbox"/> Insomnia               |
| <input type="checkbox"/> Dressing  | <input type="checkbox"/> Reading       | <input type="checkbox"/> Typing     | <input type="checkbox"/> Writing    | <input type="checkbox"/> Grasping  | <input type="checkbox"/> Using the toilet       |
| <input type="checkbox"/> Standing  | <input type="checkbox"/> Leaning       | <input type="checkbox"/> Walking    | <input type="checkbox"/> Stooping   | <input type="checkbox"/> Squatting | <input type="checkbox"/> Loss of Sexual Drive   |
| <input type="checkbox"/> Bending   | <input type="checkbox"/> Twisting      | <input type="checkbox"/> Carrying   | <input type="checkbox"/> Lifting    | <input type="checkbox"/> Pushing   | <input type="checkbox"/> Restful sleeping       |
| <input type="checkbox"/> Sitting   | <input type="checkbox"/> Driving       | <input type="checkbox"/> Sports     | <input type="checkbox"/> Exercising | <input type="checkbox"/> Reclining | <input type="checkbox"/> Loss of concentration  |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Riding in car | <input type="checkbox"/> Air Travel | <input type="checkbox"/> Climbing   | <input type="checkbox"/> Pulling   | <input type="checkbox"/> Changes in personality |
| <input type="checkbox"/> Grooming  | <input type="checkbox"/> Pinching      | <input type="checkbox"/> Kneeling   | <input type="checkbox"/> Reaching   | <input type="checkbox"/> Nervous   | <input type="checkbox"/> Tactile feeling        |
| <input type="checkbox"/> Bathing   | <input type="checkbox"/> Holding       |                                     |                                     |                                    |   |

### Past Medical History

*Please select all conditions that you have had or are currently having:*

- |   |  |   |   |  |
|---|--|---|---|--|
| <input type="checkbox"/> None                       | <input type="checkbox"/> Other                               | <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Abnormal Weight gain/loss    | <input type="checkbox"/> Angina                    |
| <input type="checkbox"/> Anorexia                   | <input type="checkbox"/> Anxiety                             | <input type="checkbox"/> Aortic aneurysm          | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Bladder infection          | <input type="checkbox"/> Blood disorder                      | <input type="checkbox"/> Breast lumps             | <input type="checkbox"/> Breast Soreness              | <input type="checkbox"/> Bronchitis                |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Cardiovascular disease/heart attack | <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Chronic cough                | <input type="checkbox"/> Chronic sinusitis         |
| <input type="checkbox"/> Colitis                    | <input type="checkbox"/> Constipation                        | <input type="checkbox"/> Convulsions              | <input type="checkbox"/> COPD                         | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Dermatitis, Eczema/Rash    | <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Difficulty in swallowing | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Emphysema                 |
| <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Epilepsy                            | <input type="checkbox"/> Excessive thirst         | <input type="checkbox"/> Fainting                     | <input type="checkbox"/> Frequent urination        |
| <input type="checkbox"/> General fatigue            | <input type="checkbox"/> Gout                                | <input type="checkbox"/> Hand pain                | <input type="checkbox"/> Headache                     | <input type="checkbox"/> Heart attack              |
| <input type="checkbox"/> Heart disease              | <input type="checkbox"/> Heartburn/Indigestion               | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> High cholesterol          |
| <input type="checkbox"/> High PSA                   | <input type="checkbox"/> High triglycerides                  | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Irregular menstrual flow     | <input type="checkbox"/> Irritable colon           |
| <input type="checkbox"/> Jaw pain                   | <input type="checkbox"/> Kidney disorders                    | <input type="checkbox"/> Kidney stones            | <input type="checkbox"/> Liver/Gallbladder problems   | <input type="checkbox"/> Loss of appetite          |
| <input type="checkbox"/> Loss of bladder control    | <input type="checkbox"/> Low back pain                       | <input type="checkbox"/> Lung Disease             | <input type="checkbox"/> Mental Disease               | <input type="checkbox"/> Mid back pain             |
| <input type="checkbox"/> Muscular in coordination   | <input type="checkbox"/> Neck pain                           | <input type="checkbox"/> Osteoarthritis           | <input type="checkbox"/> Pain in ankle or foot        | <input type="checkbox"/> Pain in lower leg or knee |
| <input type="checkbox"/> Pain in upper arm or elbow | <input type="checkbox"/> Pain in upper leg and hip           | <input type="checkbox"/> Painful urination        | <input type="checkbox"/> PMS                          | <input type="checkbox"/> Pneumonia                 |
| <input type="checkbox"/> Profuse menstrual flow     | <input type="checkbox"/> Prostate problems                   | <input type="checkbox"/> Rapid heart beat         | <input type="checkbox"/> Renal Disease                | <input type="checkbox"/> Rheumatoid arthritis      |
| <input type="checkbox"/> Scoliosis                  | <input type="checkbox"/> Shoulder pain                       | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Swelling/stiffness of joints | <input type="checkbox"/> Thyroid disease           |
| <input type="checkbox"/> Tinnitus (ear noises)      | <input type="checkbox"/> Tuberculosis                        | <input type="checkbox"/> Tumor                    | <input type="checkbox"/> Ulcer                        | <input type="checkbox"/> Visual disturbances       |
| <input type="checkbox"/> Wrist pain                 |  |   |   |  |

## INITIAL EVALUATION – Automobile Accident

### Family History

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

- |   |  |   |   |  |
|---|--|---|---|--|
| <input type="checkbox"/> None                       | <input type="checkbox"/> Other                               | <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Abnormal Weight gain/loss    | <input type="checkbox"/> Angina                    |
| <input type="checkbox"/> Anorexia                   | <input type="checkbox"/> Anxiety                             | <input type="checkbox"/> Aortic aneurysm          | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Bladder infection          | <input type="checkbox"/> Blood disorder                      | <input type="checkbox"/> Breast lumps             | <input type="checkbox"/> Breast Soreness              | <input type="checkbox"/> Bronchitis                |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Cardiovascular disease/heart attack | <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Chronic cough                | <input type="checkbox"/> Chronic sinusitis         |
| <input type="checkbox"/> Colitis                    | <input type="checkbox"/> Constipation                        | <input type="checkbox"/> Convulsions              | <input type="checkbox"/> COPD                         | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Dermatitis, Eczema/Rash    | <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Difficulty in swallowing | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Emphysema                 |
| <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Epilepsy                            | <input type="checkbox"/> Excessive thirst         | <input type="checkbox"/> Fainting                     | <input type="checkbox"/> Frequent urination        |
| <input type="checkbox"/> General fatigue            | <input type="checkbox"/> Gout                                | <input type="checkbox"/> Hand pain                | <input type="checkbox"/> Headache                     | <input type="checkbox"/> Heart attack              |
| <input type="checkbox"/> Heart disease              | <input type="checkbox"/> Heartburn/Indigestion               | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> High cholesterol          |
| <input type="checkbox"/> High PSA                   | <input type="checkbox"/> High triglycerides                  | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Irregular menstrual flow     | <input type="checkbox"/> Irritable colon           |
| <input type="checkbox"/> Jaw pain                   | <input type="checkbox"/> Kidney disorders                    | <input type="checkbox"/> Kidney stones            | <input type="checkbox"/> Liver/Gallbladder problems   | <input type="checkbox"/> Loss of appetite          |
| <input type="checkbox"/> Loss of bladder control    | <input type="checkbox"/> Low back pain                       | <input type="checkbox"/> Lung Disease             | <input type="checkbox"/> Mental Disease               | <input type="checkbox"/> Mid back pain             |
| <input type="checkbox"/> Muscular in coordination   | <input type="checkbox"/> Neck pain                           | <input type="checkbox"/> Osteoarthritis           | <input type="checkbox"/> Pain in ankle or foot        | <input type="checkbox"/> Pain in lower leg or knee |
| <input type="checkbox"/> Pain in upper arm or elbow | <input type="checkbox"/> Pain in upper leg and hip           | <input type="checkbox"/> Painful urination        | <input type="checkbox"/> PMS                          | <input type="checkbox"/> Pneumonia                 |
| <input type="checkbox"/> Profuse menstrual flow     | <input type="checkbox"/> Prostate problems                   | <input type="checkbox"/> Rapid heart beat         | <input type="checkbox"/> Renal Disease                | <input type="checkbox"/> Rheumatoid arthritis      |
| <input type="checkbox"/> Scoliosis                  | <input type="checkbox"/> Shoulder pain                       | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Swelling/stiffness of joints | <input type="checkbox"/> Thyroid disease           |
| <input type="checkbox"/> Tinnitus (ear noises)      | <input type="checkbox"/> Tuberculosis                        | <input type="checkbox"/> Tumor                    | <input type="checkbox"/> Ulcer                        | <input type="checkbox"/> Visual disturbances       |
| <input type="checkbox"/> Wrist pain                 |  |   |   |  |

## Surgical History

Please select all surgeries that you have had in the past.

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> None                  | <input type="checkbox"/> Other                                       | <input type="checkbox"/> Abdominal Exploration  | <input type="checkbox"/> Abdominoplasty       | <input type="checkbox"/> Abortion               |
| <input type="checkbox"/> ACL Reconstruction    | <input type="checkbox"/> Adenoid Removal                             | <input type="checkbox"/> Angioplasty            | <input type="checkbox"/> Appendectomy         | <input type="checkbox"/> Bone Fracture Repair   |
| <input type="checkbox"/> Breast Lump Removal   | <input type="checkbox"/> Bunion Remova                               | <input type="checkbox"/> Carotid Artery Surgery | <input type="checkbox"/> Cataract Surgery     | <input type="checkbox"/> Cervical spine Surgery |
| <input type="checkbox"/> Cholecystectomy       | <input type="checkbox"/> Cosmetic Breast Burgery                     | <input type="checkbox"/> C-Section              | <input type="checkbox"/> Facelit              | <input type="checkbox"/> Gallbladder Removal    |
| <input type="checkbox"/> Gastric Bypass        | <input type="checkbox"/> Heart Bypass Surgery                        | <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Hemorrhoid Surgery   | <input type="checkbox"/> Hernia Repair          |
| <input type="checkbox"/> Hip Joint Replacement | <input type="checkbox"/> Hysterectomy                                | <input type="checkbox"/> Kidney Transplant      | <input type="checkbox"/> Knee Arthroscopy     | <input type="checkbox"/> Knee Joint Replacement |
| <input type="checkbox"/> Knee surgery          | <input type="checkbox"/> LASIK Eye Surgery                           | <input type="checkbox"/> Liposuction            | <input type="checkbox"/> Lumbar spine surgery | <input type="checkbox"/> Mastectomy             |
| <input type="checkbox"/> Prostate Removal      | <input type="checkbox"/> Rotator Cuff Surgery                        | <input type="checkbox"/>                        | <input type="checkbox"/> TMJ Surgery          | <input type="checkbox"/> Tonsillectomy          |
| <input type="checkbox"/> Vasectomy             | <input type="checkbox"/> Surgical History was rev'd not contributory |   |   |   |

## Medications

Please select all medications that you are currently taking:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> None            | <input type="checkbox"/> Other               | <input type="checkbox"/> Advil                     |
| <input type="checkbox"/> Ambien          | <input type="checkbox"/> Analgesics          | <input type="checkbox"/> Anti-inflammatories       |
| <input type="checkbox"/> Aspirin         | <input type="checkbox"/> Atenolol            | <input type="checkbox"/> Blood Pressure Medication |
| <input type="checkbox"/> Daily Vitamins  | <input type="checkbox"/> Diabetes Medication | <input type="checkbox"/> Flexeril                  |
| <input type="checkbox"/> Isorsubrine     | <input type="checkbox"/> Monopril            | <input type="checkbox"/> Motrin                    |
| <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> Pin Medication      | <input type="checkbox"/> Skelaxin                  |
| <input type="checkbox"/> Synthroid       | <input type="checkbox"/> Tylenol             | <input type="checkbox"/> Vicodin                   |

## Allergies

Please select all items that you are allergic to:

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

## 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