## Auto Injury History



Name: ________________________________ Date: ____________________

Vehicles Involved:
YOUR Vehicle – Year: ______ Make: ______ Model: ______ OTHER Vehicle – Year: ____ Make: ______Model: ________
Accident Type: [ ] Rear Ended [ ] Head-on [ ] Broad-sided Your speed: ___________Other Vehicle Speed: ____________
Damage to Your Vehicle:$______________________________Other Vehicle Damage:$______________________________
Describe Accident:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Specifics of Accident (Mark each that applies to the accident):

You were the [ ] Driver [ ] Passenger
Sitting [ ] Front Seat [ ] Back Seat
[ ] Seat Belted [ ] No Seat belt
Impending Collision [ ] Aware [ ] Unaware
[ ] Braced [ ] Not Braced
Head Did [ ] Strike Object [ ] Not Strike Object
[ ] Broken Glass
Did you experience [ ] Shock [ ] Loss of Consciousness

State you Emotions and Physical State Immediately Following the accident:
________________________________________________
________________________________________________

What were the Road and Weather Conditions:
[ ] Clear [ ] Raining
[ ] Wet [ ] Dry
[ ] Sunny [ ] Cloudy

Immediately Following the Accident
[ ] Ambulance – Paramedics Called
[ ] Treated at Scene
[ ] Transported to Hospital by Ambulance
[ ] Went to Hospital on Their Own
[ ] Diagnostics Performed at Hospital
[ ] Treatment at Hospital
[ ] Medication Prescribed
[ ] Follow-up Recommended

Other Doctors Seen:
[ ] Orthopedist [ ] Neurologist
[ ] Psychiatrist [ ] Physical Therapist
[ ] Massage Therapist [ ] Chiropractor

State your Emotions & Physical State after the first few days:
________________________________________
________________________________________

Symptoms Immediately Following the Accident (Pain Characteristics for Each Area of Complaint:

The pain started: ________________________________________________
The pain is made better by: ________________________________________
And worse by: ________________________________________
The pain had the following qualities: ________________________________

[ ] There is [ ] There is not radiation into: ________________________________
[ ] There is [ ] There is not referred pain into: ____________________________
[ ] There is [ ] There is not parasthesia (tingling/numbness) into: ____________________

The pain is located: ________________________________________________

The pain is (as far as timing is concerned): ________________________________

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Daily Activities

How many days out of an average week do you have pain?: _________

How much time out of an average day are you in pain?: ___________

What are the worst times of day for the pain?: ________________

What are the best times of day for the pain?: _________________

How do the following activities affect your pain?:

| | No Change | Relieves | Increased | Duration |
|---|---|---|---|---|
| Sitting | [ ] | [ ] | [ ] | ______ |
| Walking | [ ] | [ ] | [ ] | ______ |
| Standing | [ ] | [ ] | [ ] | ______ |
| Lying Down | [ ] | [ ] | [ ] | ______ |
| Looking Up | [ ] | [ ] | [ ] | ______ |
| Looking Down | [ ] | [ ] | [ ] | ______ |
| Lifting | [ ] | [ ] | [ ] | ______ |

Pain Rating

On a scale of 1-10 rate you pain:

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Describe the overall severity of the pain:

[ ] Mild Nuisance
[ ] Mild to moderate but can live with it
[ ] Moderate, having trouble coping with
[ ] Severe, it is ruining my quality of life

Progression

How is your pain compared to when the pain episode first started?:

[ ] Much improved
[ ] A little worse
[ ] Somewhat improved
[ ] Much Worse
[ ] No Change

What do you do to relieve the pain?:

______________________________________________________________

Please mark each that apply to your Daily Activities:

[ ] Stays at home most of the time due to the problem.
[ ] Changes position frequently to try and get comfortable.
[ ] Walks more slowly than usual because of the problem.
[ ] Does not do the jobs around the house because of the problem.
[ ] Has to use handrails to get stairs, etc.
[ ] Has to lie down and rest frequently due to the problem.
[ ] Has to hold onto something to sit or stand from a chair.
[ ] Has to get other people to do thins for you.
[ ] Has difficulty getting dressed due to the problem.
[ ] Can only stand for short periods due to the problem.
[ ] Has difficulty bending or kneeling due to the problem.
[ ] Has difficulty turning over in bed due to the problem.
[ ] Has a loss of appetite due to the problem.
[ ] Can only walk short distances because of the problem.
[ ] Has a loss of appetite due to the problem.
[ ] Can only walk short distances because of the problem.
[ ] Has difficulty sleeping because of the problem.
[ ] Has to get dressed with someone's help.
[ ] Has to sit most of the day because of the problem.
[ ] Has more irritable because of the problem.
[ ] Has difficulty Clinging Stairs.
[ ] Stays In bed most of the day because of the problem.

What are some recreational activities that you participated in Before this current problem and which ones cannot be Performed now to the same extent?:

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

How often do you have to stop activities and sit or lie down to Control your symptoms?:

[ ] Several times a day
[ ] Occasionally
[ ] Approximately once per day
[ ] Never
[ ] All day

## Auto Injury History



Name: ______________________________ Date: ________________

Social History

[ ] Single
[ ] Married
[ ] Divorced
Number of children:____

[ ] Smoker
[ ] Non-Smoker
[ ] Drinks Alcohol
[ ] Does not drink Alcohol
[ ] Take Drugs
[ ] Does not take Drugs

List your Hobbies & Exercise Activities:

______________________________________

______________________________________

______________________________________

Occupational History

Your Employer: ____________________

Job Title:__________________________

What is your current job satisfaction:

[ ] Very Satisfied
[ ] Satisfied
[ ] Dissatisfied
[ ] Very Dissatisfied

Are you Job Duties Physically demanding for you?: [ ] Yes [ ] No
Have you had any disability time?: [ ] Yes [ ] No
If you are currently working which are you performing?:

[ ] Regular Duties
[ ] Limited – Light Duties

Your highest level of education attained?:

______________________________________

Medical History

List the Physicians and other practitioners you have seen for your problem:

______________________________________
______________________________________
______________________________________
______________________________________

List the Medications you are currently taking:

______________________________________
______________________________________
______________________________________
______________________________________

List the treatments you have had for you problem:

[ ] Hot packs/Ultrasound
[ ] Massage
[ ] Electrical Stimulation
[ ] TENS Unit
[ ] Body Mechanics Training
[ ] Strengthening Exercises
[ ] Aerobics
[ ] Gravity Inversion-Traction
[ ] Bed Rest

[ ] Chiropractic
[ ] Osteopathy
[ ] Biofeedback
[ ] Trigger Point Injections
[ ] Epidural Injections
[ ] Back Brace
[ ] Acupuncture
[ ] Naturopathy

List the types of Diagnostic Testing that has been performed for this problem:

[ ] X-Rays
[ ] CT Scan
[ ] Myelogram
[ ] MRI Scan

[ ] Discogram
[ ] Bone Scan
[ ] EMG

List Past Surgeries: [ ] None

______________________________________
______________________________________
______________________________________

List Past Hospitalizations: [ ] None

______________________________________
______________________________________

List previous back, neck and musculoskeletal problems you have had:

______________________________________
______________________________________
______________________________________
______________________________________
______________________________________
______________________________________

**Auto Injury History**



Name: ______________________________ Date: ________________

Medical History

Mark if you have had any of the following symptoms in the past **5 years**:

[ ] Unexplained fevers
[ ] Night Sweats
[ ] Weight loss of 10 lbs or more
[ ] Loss of appetite
[ ] Excessive fatigue
[ ] Problems with depression
[ ] Difficulty sleeping
[ ] Unusual stress at work
[ ] Unusual stress at home
[ ] Easy bruising
[ ] Excessive bleeding
[ ] Lumps in neck, armpit or groin
[ ] Chest pain or tightness
[ ] Persistent or unusual cough
[ ] Trouble breathing with exercise
[ ] Trouble breathing lying flat
[ ] Coughing up blood
[ ] Diabetes

[ ] Swollen ankles
[ ] Stomach pain
[ ] Change in bowel habits
[ ] Persistent diarrhea
[ ] Excessive constipation
[ ] Dark black stools
[ ] Blood in stools
[ ] Pain – burning when urinating
[ ] Difficulty urinating-start/stop
[ ] Blood in urine
[ ] Need to urinate more at night
[ ] Morning stiffness
[ ] Persistent eye redness
[ ] Muscle tenderness
[ ] Dry eyes or mouth
[ ] Skin rashes
[ ] Joint pain or swelling
[ ] High Blood Pressure

Females – Mark if any apply:

[ ] Vaginal Bleeding other than period
[ ] Pap smear within last 2 years
[ ] Painful menstrual periods
[ ] Back pain with menstrual periods
[ ] Other menstrual problems

Do you have any current problem with:

[ ] Anxiety
[ ] Depression
[ ] Irritability
[ ] Dizziness or Nausea

Do you have a home exercise program that you follow on a regular basis?:

[ ] Yes [ ] No