

## Accident Information

Location of accident (City & State) \_\_\_\_\_ Time of the accident \_\_\_\_\_

Were you wearing a seat belt                      Yes              No              Was your vehicle totaled              Yes              No

Did you go the hospital by ambulance              Yes              No              Were the police called              Yes              No

Were you aware of the pending accident              Yes              No              Did you lose consciousness              Yes              No

Describe the accident \_\_\_\_\_

## Current Symptoms

**Please check if you have experienced any of the following conditions since the accident:**

<input type="checkbox"/> Anxiety/fear of being in car	<input type="checkbox"/> Headaches	<input type="checkbox"/> Loss/diminished hearing
<input type="checkbox"/> Back pain	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Nausea
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Clicking in jaw	<input type="checkbox"/> Leg/knee pain	<input type="checkbox"/> Numbness/tingling in arms/legs
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Eating/chewing difficulties	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Shoulder pain

**Please mark the activities that you have not been able to do normally:**

<input type="checkbox"/> Bathing/Showering	<input type="checkbox"/> Lifting	<input type="checkbox"/> Sleeping
<input type="checkbox"/> Bending	<input type="checkbox"/> Personal grooming/hygiene	<input type="checkbox"/> Social events
<input type="checkbox"/> Cooking	<input type="checkbox"/> Playing with children	<input type="checkbox"/> Standing
<input type="checkbox"/> Dressing	<input type="checkbox"/> Reading	<input type="checkbox"/> Sports
<input type="checkbox"/> Eating	<input type="checkbox"/> Riding in the car	<input type="checkbox"/> Telephone
<input type="checkbox"/> Holidays	<input type="checkbox"/> Sexual relations	<input type="checkbox"/> Vacation
<input type="checkbox"/> House cleaning	<input type="checkbox"/> Shaving	<input type="checkbox"/> Watching TV
<input type="checkbox"/> Ironing	<input type="checkbox"/> Shopping	<input type="checkbox"/> Working on computer/internet
<input type="checkbox"/> Laundry	<input type="checkbox"/> Sitting	<input type="checkbox"/> Yard work

**Please state how long/much you can do the following activities before the onset of pain &**

**Rate your pain on a scale of 0-10 with 10 being highest:**

Bending	_____ Minutes	_____ /10 Pain	Sleeping	_____ Minutes	_____ /10 Pain
Computer/Typing	_____ Minutes	_____ /10 Pain	Standing	_____ Minutes	_____ /10 Pain
Lifting	_____ Pounds	_____ /10 Pain	Telephone	_____ Minutes	_____ /10 Pain
Sitting	_____ Minutes	_____ /10 Pain	<b>What is your pain today?</b>	_____ /10 Pain	

**Please list any physicians or medical facilities that you have seen regarding this accident:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Do have any allergies to medication?**

Medications \_\_\_\_\_

Reactions \_\_\_\_\_

**Are you currently taking any prescriptions or over-the-counter medications?**

Medications \_\_\_\_\_ Strength \_\_\_\_\_ Dosing \_\_\_\_\_

