CASE NO. ______________ PATIENTS NAME ______________

ADDRESS ______________

TELEPHONE (________)______________

DATE OF BIRTH ______________ SEX ______________ OCCUPATION ______________

DATE:	HT:	WT:	AGE:

Date of your accident:

What parts of your body were injured during the accident ?

Are there any complaints of numbness or tingling ?

Are you left or right hand dominant ?

What was your position sitting in the vehicle ? (circle one)

Driver Front Passenger Rear Right Rear Left Other

Were you wearing a seat belt ? Yes No (Harness Lap Both)

Was your car MOVING or STOPPED (circle one) IN TRAFFIC OR STOPPED

If moving, what was your approx. speed at time of impact ?

Were you HIT or did YOU HIT ANOTHER VEHICLE ? (circle one)

If your were hit, where: rear ended back driver side back passenger side head on
front driver side front passenger side other:

If you were the driver did you have both hands on the steering wheel ? Yes No Other

If your were the passenger did you brace with your hands on impact ? Yes No

Did any part of your body come in contact with any part of the vehicle ? Yes No

If yes describe:

Describe your body movement at time of impact:

How many vehicles were involved in the accident ?

Did you lose consciousness ? Yes No, if yes how long ?

Did you go to the hospital after the accident ? If yes, when ?

Were you taken by ambulance ? Yes No Name of Hospital:

Did you seek treatment with a Doctor after the hospital ? Yes No

	Name of Doctor:	Specialty:	Date of first visit	Are you still treating with Dr.
1.				
2.				
3.				
4.				

OVER

What tests did you have	Where	What body part
X-RAYS		
MRI		
CT SCAN		
EMG		

Did you have any Physical Therapy treatments ? (if yes) Where ?

When did you start treatments? Are you currently going? YES NO

What type of treatments have you received? (circle) HOT PACKS ELECTRIC STIMULATION
EXERCISE ULTRA SOUND TRACTION ICE MANIPULATION
OTHER:

How often do you or did you go? Is it or did it help you? Yes No

Have you missed any work due to the accident? Yes No (if Yes) How long?

~~~~~~PRIOR INJURIES~~~~~~

Have you had any prior motor vehicle accidents or significant injuries? YES NO When?

What areas of the body were involved in any PRIOR accident?

Were these injuries resolved prior to your current injuries? YES NO

If no, what complaints remain?

Are you still treating for these injuries? YES NO

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List any fractures/sprains:

List any surgeries:

List or circle medical problems:

Hypertension	**Diabetes**	**Asthma**	**Epilepsy / seizure disorder**
Heart attack	**Migraines**	**Stroke**	**Cardiac disease**
Ulcers	**Cancer**	**Anemia**	**Thyroid disease**

List all current medications:

Are you allergic to any medications?

Do you smoke?

Do you drink alcohol?
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