Respiratory-
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Painful breathing

Gastrointestinal-
- ☐ Constipation / Diarrhea
- ☐ Change in appetite
- ☐ Nausea

Urinary-
- ☐ Increased Frequency
- ☐ Incontinence
- ☐ Blood in urine

Musculoskeletal-
- ☐ Muscle or joint pain
- ☐ Redness of joints
- ☐ Swelling of joints

Neurologic-
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures

Psychiatric-
- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss

CAR ACCIDENT INFORMATION

This form must be completed in addition to our registration/update form. If you do not have all of the necessary information, please ask to use our phone to talk with your agent to obtain the information. To bill insurance carriers we must have all of the information as noted below. If for any reason you are unable to reach your agent, please be prepared to pay for today's visit. Note, however, you must still turn in this form if you are to be reimbursed by the car insurance carrier.

Patient's Name _____ Date of Birth _____

Date and Time of Accident _____

Name of Insured _____

Name of Insurance Company _____

Insurance Billing Address _____

Insurance Company Phone Number _____

Name of Insurance Agent _____

Insurance Claim Number _____

Explain way in which accident occurred _____

_____

_____

Were you ❑ The Driver ❑ Passenger ❑ Pedestrian ❑ Other

If Other (above), please explain _____

_____

Description of injury, location of pain _____

_____

_____

I understand that, by signing, I authorize I.F.H.C. and my doctors to release any and all records pertaining to this accident to the above named insurance carrier. Additionally, I understand that, if for any reason the above named insurance company does not make the payment in full for services rendered, I am responsible for the charges. I agree to make the prompt payment in full upon notification of any outstanding balances not covered by the insurance carrier.

Signed _____ Date ____/____/____

(Patient, Parent, Legal Guardian)

FOR OFFICE USE ONLY

Ins. Phone _____

Ins. Name _____

Billing Address _____

_____

Is Authorization Necessary? Yes or No

Who Authorized _____

PPO (?) Yes or No

Claims Phone Number _____

Can we see and treat? Yes or No

Authorization Number _____

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MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Thank you in advance for taking the time to complete this form, this will help us to better assess all of your pain concerns and provide you with the best treatment.

NAME: _____ DATE: _____

Date of Injury: _____ Age: _____

Accident Details:

1. What kind of vehicle were you in?:
   Year - _____
   Make - _____
   Model - _____

2. Where were you seated? (circle): Driver / Front passenger / Rear left / Rear right

3. Were you wearing your seat belt? (circle): Yes / No

4. Did the airbags deploy? (circle): Yes / No

5. What was your body position at impact? (circle):

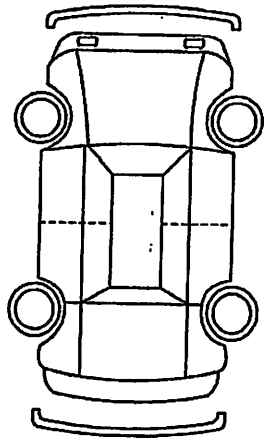
-Looking straight / Looking right / Looking left / _____

-Both hands on wheel / Right hand on wheel / Left hand on wheel / Hands in lap

-Right foot on brake / Right foot on gas / Left foot on floorboard / Both feet on floorboard

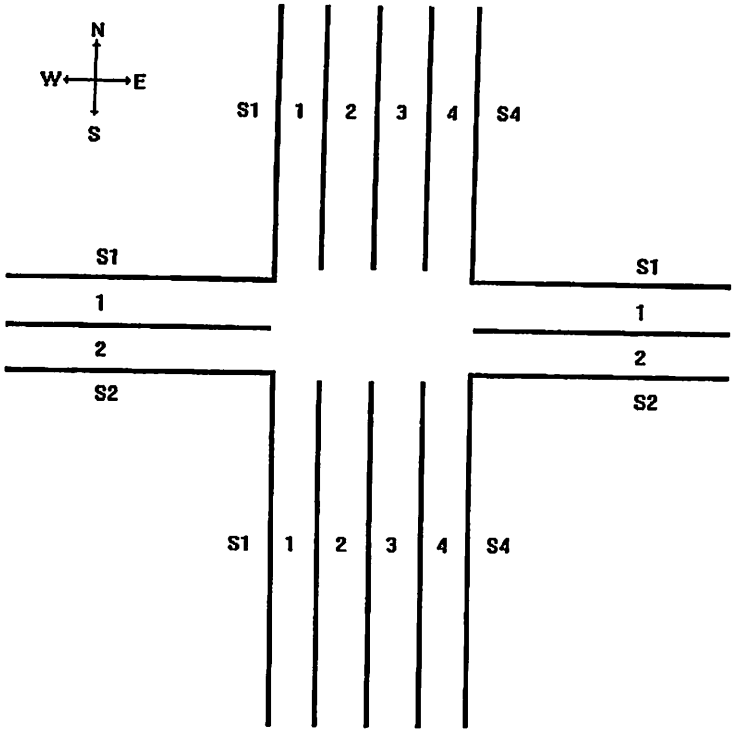
6. Where was the damage to your vehicle?:

Front: Driver Side Passenger Side



7. What kind of vehicle struck you?: _____

8. If possible, please roughly draw out what happened in the accident:



9. How fast was your vehicle traveling? (approximately): _____ mph

10. How fast was the other vehicle traveling? (approximately): _____ mph

11. Were you prepared for the impact, did you brace yourself? (circle): Yes / No

12. Did you lose consciousness? (circle): Yes / No

13. Were you in a daze, felt dizzy, disoriented, confused, etc ?. (circle): Yes / No

a. How long? _____ (ex. couple of seconds, 5 minutes, etc.)

If you answered YES to either **question 12 or 13,** please fill out question 13a

14. Where did you go for medical treatment?: _____

15. Were you taken by ambulance? (circle): Yes / No

13a. After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you ***now suffer*** from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, **please circle the number closest to your answer.**

0 = Not experienced at all, 1 = No more of a problem, 2 = A mild problem,

3 = A moderate problem, 4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4

Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? (please list)

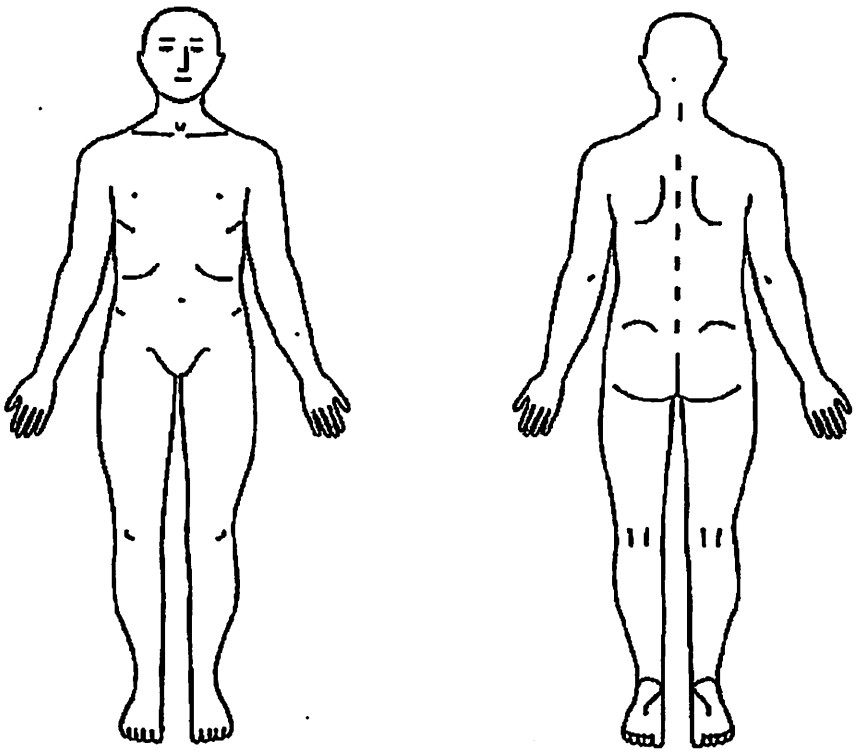
1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

Please take a moment to specifically identify your pain:

B2. Pain drawing

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	—	INC Sensitivity	0000
Constant	xxx	Sharp Twinge	////
Throbbing Ache	xxx		



What is your pain level at rest? (circle):

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

What is your pain level with activity? (circle):

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

How would you describe your pain? (circle):

Deep-pressure	Tightness	Spasms
Tingling	Numbness	Pinprick
Burning	Sharp-shooting	Stabbing

Is your pain (circle): Constant Intermittent

Since the accident, is your pain (circle): Unchanged Worse Better

What makes your pain **worse?** (circle):

Activity - Bending / Lifting / Walking / Sitting / _____

What makes your pain **better?** (circle):

Medications / Ice / Heat / Chiropractic / Rest / _____

Do you have any weakness? (circle): Yes / No --- +/or numbness? Yes / No

-If yes, where (circle): Left: Arm Leg --- Left: Arm Leg
Right: Arm Leg --- Right: Arm Leg

Do you have any loss of control or changes of your bowel or bladder? (circle): Yes / No

What treatments have you had following this accident? (circle):

Physical therapy	Heating pad	Ice pack	Injections	Chiropractic
Epidural injections	Surgery	Massage	Medications	Acupuncture

How has this accident affected your life?

_____

_____

Have you missed work? (circle): Yes / No

-If yes, how much: _____

-Have you returned to work?d (circle): Yes / No

-Have you **EVER** been in another **motor vehicle, work or any other type of injury?**

1. _____

2. _____

3. _____

MEDICAL CONDITIONS (Please list: such as diabetes, depression, gastric reflux):.

MEDICATIONS (Tylenol, ibuprofen, Motrin, Alleve):_____

SURGERIES:_____

ALLERGIES: _____

FAMILY HISTORY:

FATHER – age ____, alive (circle): Yes / No
- medical conditions:_____

MOTHER – age ____, alive (circle): Yes / No
- medical conditions:_____

SOCIAL HISTORY:

Tobacco use (circle): Yes / No
Alcohol use (circle): Yes / Social / No
Drug use (circle): Yes / No

REVIEW OF SYSTEMS: *(mark only if positive)*

General-	**Skin-**	**Head-**	**Ears-**
□ Weight loss or gain	□ Rashes	□ Headache	□ Decreased hearing
□ Fatigue	□ Dryness	□ Head injury	□ Ringing in ears
□ Fever or chills	□ Lumps		□ Earache
Eyes-	**Nose-**	**Neck-**	**Cardiovascular-**
□ Glasses or contacts	□ Discharge	□ Lumps	□ Chest pain
□ Blurry or double vision	□ Itching	□ Swollen glands	□ Tightness
□ Flashing lights	□ Nosebleeds		□ Palpitations