Essence of Life
Spinal Care

5811 Memorial Hwy. Suite 106 Tampa, FL 33615 Phone: 813-330-0232 Fax: 813-345-4075

Health History & Personal Injury Accident Report

PATIENT INFORMATON

Patient Name: _____ Today's Date: _____ D.O.B._____

Social #: _____-_____-_____ Email: _____

Full Home Address: _____

_____

Cell number: _____ Home or work #:_____

Marital status: (circle) Married single divorced widowed

Children? NONE YES If yes, how many? _____

How did you find us: _____

Emergency contact Name: _____ Number: _____

Relation to you: _____

ACCIDENT REPORT

Date of Accident:_____ Time of Accident: _____

Where did the accident happen?_____ City _____ State_____

Describe the accident in your own words: _____

_____

_____

_____

_____

_____

_____

What was your position in the vehicle? (Circle) Driver or Passenger

If passenger, were you sitting in: (Circle) Front Right rear Left rear

Did your vehicle strike the other vehicle? (Circle) YES NO

Was the impact from: (Circle) Front Left side Right side Rear

At the time of impact were you: (Circle) Looking straight ahead Looking right Looking left

Were both hands on the steering wheel? YES NO Was your foot on the brake? YES NO

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Name _____ Date:_____

Were you braced for impact? YES NO

Were you wearing a seat belt? YES NO If yes, (Circle) Shoulder belt or Lap Belt

Where in the vehicle were you after the accident? _____

Did you strike anything in the vehicle after the impact? YES NO Dazed, cannot remember

If yes, which one(s)? Windshield Headrest Dashboard Steering wheel Back of seat

Door frame Side window Rear view mirror Rear window of pickup Side window

Which part of your body? Chest Chin Head Face Neck Back Hand R L Wrist R L

Arm R L Elbow R L Shoulder R L Leg R L Knee R L Ankle R L Other _____

Immediately after the accident how did you feel? _____

_____

Were you: (Circle) Conscious Unconscious Cut or bleeding In a daze

Did you have: Head pain (headache) Neck pain R L Upper back pain R L Mid back pain R L

Low back pain R L Lower extremity pain R L Upper extremity pain R L

When did the Pain begin? (Circle) Immediately Shortly after Several hours later Several days

List the extent of injuries as you know them: _____

_____

Did you report the accident: YES NO To Whom: _____

Did you go to the hospital? YES NO When? At time of accident Next day Other _____

How did you get there: (Circle) Ambulance Private transportation NA

Did the ambulance attendants place you in: (Circle) Neck collar Splints Brace NA

Name of Hospital: _____ Attended by Doctor: _____

Were you X-Rayed at the hospital? YES NO

If so, What was the diagnosis_____

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Name _____ **Date:**_____

Were you admitted to the hospital? YES NO If so, how long? _____

What treatment was rendered? _____

At hospital did you see: (Circle) Your own Doctor Orthopedic Doctor Physical therapist

Have you seen any other doctor as a result of this accident? YES NO

If yes, Name: _____ Date: _____

If you did not go to the hospital did you: (Circle) Go Home Go to work Go to the doctor

If you went home did you: (Circle) Go to bed Take it easy Go about normal business

Is your pain: (Circle) Constant On and Off Sharp Dull Other: _____

If your pain radiating? YES NO **If yes, where?** _____

Is your pain worse:

When rising? Y N When Straining? Y N When Coughing? Y N When Sneezing? Y N

When straining during bowel movements? Y N When stretching or twisting? Y N

With a change in heel height? Y N

What is your most common position? Sitting Standing Lying - Rt side Lt side Back Stomach

Is it difficult for you to move around in bed? YES NO

Do you have: A firm mattress? YES NO A cervical pillow? YES NO

Does any of the following relieve your pain? Heating pad Hot bath Shower Ice pack Brace

Do you feel better: (Circle) Moving around Resting

Do your knees ache or hurt? YES NO

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Name _____ Date:_____

Circle the symptoms you have noticed since the accident:

Headache	Irritability	Face flushed	Ear ringing
Neck pain	Chest pain	Light bothers eyes	Buzzing in ears
Neck stiffness	Dizziness	Shortness of breath	Loss of memory
Muscle tension	Fever	Numbness in toes	Cold sweats
Back pain	Fatigue	Numbness in fingers	Fainting spells
Nervousness	Depression	Pins & needles in arms	Loss of smell
Loss of balance	Cold feet	Pins & needles in legs	Loss of taste
Upset stomach	Cold hands	Head seems too heavy	Leg cramps
Diarrhea	Constipation	Change in bowel habits	Incontinence
Numbness on one side of face or body		Speech difficulty	Difficulty swallowing
Double vision	Nausea	Loss of vision	

Have you had similar symptoms prior to this accident? YES NO

If yes, which ones? _____

Did you enjoy good health prior to this accident? YES NO

If no, please explain:_____

Have you had any previous accidents? YES NO

If yes, please describe:_____

Have you lost any time from work because of this accident? YES NO How much? _____

Are you: Self-employed Employed Not employed Retired Disabled Veteran N/A

If employed what is your occupation? _____

Are you currently working? Y N (circle) Full time Part time Impaired function Normal function
Are you working with an attorney? YES NO Name _____

Attorney Address _____
Attorney Phone number _____

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SOCIAL HISTORY

Do you exercise routinely? *(circle)* No Yes If *Yes*, what exercise/how often? _____

Have you ever smoked? *(circle)* No Yes (Circle) Cigar Pipe Cigarettes Marijuana
If *Yes*: # per day _____

If you have never smoked, skip this: **Do you still smoke now?** No Yes **If *No*,** when did you quit? _____

Caffeine: Do you drink *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes #/day _____

Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt., etc.)*

_____Ar
e you under a lot of pressure at work or at home? *(circle)* No Yes, Which? _____

PAST MEDICAL HISTORY

Medical Conditions *(list any chronic conditions which you have been diagnosed. If not present below, CIRCLE all that apply)*

Cataracts	Heart Disease	Ulcers	Anemia	Depression
Glaucoma	Heart Murmur	Digestive Disorder	Bleeding Disorders	Frequent Infection
Asthma	High Blood Pressure	Hemorrhoids	Bone or Joint Disease	Cancer (type)
Allergies	Pneumonia	Kidney Disease		
Stroke	TB/Lung Disease	Kidney Stone(s)	German Measles	High Cholesterol
Seizures/Epilepsy	Pleurisy	Diabetes or Prediabetes	Rheumatic Fever	Prostate Enlargement
Heart Attack or Angina	Jaundice or Liver Disease		Chicken Pox	Migraines
		Thyroid Disease	Syphilis	Herniated Disc
Lupus	Fibromyalgia	Erectile Dysfunction	Infertility	

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Name _____ Date:_____

PAST SURGERIES:(List all with approximate year) _____

_____

ALLERGIES: _____

MEDICATIONS: (LIST ALL, OVER THE COUNTER AND PRESCRIBED) _____

_____

_____

PAST HISTORY OF ACCIDENTS, FALLS AND OR INJURIES (MINOR OR MAJOR, LIST YEAR) _____

_____

FAMILY MEDICAL HISTORY

Family Medical History	Age	Health *(list significant illness)*	Age at Death, If deceased. List cause.
Father			
Mother			
Brothers or Sisters			
Spouse			
Children			

SYSTEMS REVIEW

*Please indicate those items that have been a recurring or a recent significant change. **Circle below***

Constitutional/Endocrine Symptoms Good health lately Recent significant weight change Unusual-

fatigue or weakness Frequent headaches Glandular or hormone problem Heat or cold intolerance

Excessive skin dryness Excessive thirst or urination Change in hand or glove size

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SYSTEMS REVIEW (cont.) *(circle all that apply below)*

Eyes Change in vision Blurred or double vision Eye disease or injury Wear glasses/contact lenses?

Ears/Nose/Mouth/Throat/Neck Do you wear hearing aids? Hearing loss or ringing in ears?

Earaches or drainage? Chronic sinus problems or runny nose Nose bleeds
Mouth sores Bleeding gums Sore throat/hoarseness or voice change Lumps or swollen glands in neck Difficulty swallowing

Cardiovascular Chest pain Abdomen pain Palpitations Shortness of breath with walking or lying-

flat Swelling feet, ankles or hands Waking at night with shortness of breath High blood pressure

Gastrointestinal Loss of appetite Change in bowel movements Nausea or vomiting Painful

bowel movements constipation Frequent diarrhea Abdominal pains Acid Reflux

Genitourinary Change in force or strain when urinating Incontinence or dribbling of urine Sexual difficulties

Men: Testicular pain Women: Painful periods or Irregular periods Recurrent vaginal discharge

Number of pregnancies (including miscarriages): # Deliveries _____ #Miscarriages ____

Musculoskeletal Joint pain(s) Joint stiffness/swelling or warmth Weakness of muscles or joints

Muscle pain or recurrent cramps Low Back pain Cold hands or feet Hip pain Shoulder pain
Mid-back pain Neck pain

Neurological Frequent, recurring or increasing headaches Light-headedness or dizziness Convulsions

seizures or spasms Numbness or tingling sensations Tremors Paralysis Stroke Head injury

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SYSTEMS REVIEW (Cont.)

Mental Health

Have you had bouts of depression and or anxiety? *No* *Yes* _____

Have you been diagnosed to have bipolar disorder, obsessive compulsive disorder, or other psychiatric condition? Yes No

Comments:_____
_____
_____

Print Name:_____ Date: _____

Patient Signature _____