

Patient Name _____

Date _____

AUTO ACCIDENT FORM

History of Occurrence

- Pedestrian Driver Passenger Middle Front Passenger Right Front Passenger Left Rear
 Passenger Center Rear Passenger Right Rear

Patient Vehicle Type

- Compact Mid-Size Full-Size SUV Pick-Up Motorcycle

Second Vehicle

- Compact Mid-Size Full-Size SUV Pick-Up Motorcycle

Third Vehicle

- Compact Mid-Size Full-Size SUV Pick-Up Motorcycle

Road Conditions

- Dry Icy Wet Clear Foggy Dark

Road Type

- Concrete Asphalt Gravel Dirt

Were you aware the accident was going to occur? Yes No

Were you wearing your seat belt? Yes No

Did your airbag deploy? Yes No

Does your car have a head rest? Yes No Position Up Middle Down

Head Position Straight Left Right — Level Up Down

Was your car braking? Yes No

Was your car moving? Yes No

(mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the other vehicle braking? Yes No

Was the other vehicle moving?

(mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Collision Details

First Impact: Hit by another vehicle Hit another vehicle Hit by an object Hit an object
(On the) Front Front-Right Front-Left Left Right Right-Rear Left-Rear Rear Top

Second Impact: Hit by another vehicle Hit another vehicle Hit by an object Hit an object
(On the) Front Front-Right Front-Left Left Right Right-Rear Left-Rear Rear Top

Collision Results

Body was thrown Forward Backward Right Left Can't remember

Head Hit: Windshield Rear-view mirror Steering wheel Dashboard Back of Frontseat
 Side window/door Another persons body

Chest Hit: Steering wheel Dashboard Back of front seat Side window/door
 Another persons body

Shoulders Hit: Shoulder harness Side window/door Back of front seat Another persons body

Knees Hit: Steering wheel Dashboard Back of front seat Door Panel Centerconsole
 Another persons body

Hips Hit: Steering Wheel Dashboard Back of front seat Door Panel Centerconsole
 Another persons body

Vehicle Damage

First Vehicle: Totaled Significant Damage Light Damage No Damage

Second Vehicle: Totaled Significant Damage Light Damage No Damage

Third Vehicle: Totaled Significant Damage Light Damage No Damage

Were you hospitalized? Yes No

Current Symptoms: Pain Numbness Stiffness Weakness

CONTINUE WITH CHIEF COMPLAINT HPI FORM

WORK / COMP HISTORY

Date: ___/___/___

Patient _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthday _____ Sex _____ S/S# _____

Name of Compensation Carrier _____ Phone () _____

Address of Carrier _____ City _____ State _____ Zip _____

Employer's Name _____ Phone () _____

Employer's Address _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? () Yes () No

3. Previous Workers' Compensation Injury: () Yes () No

4. Accident reported to employer? () Yes () No Name of person reported accident to _____

5. Injured at _____ City _____ State _____ Zip _____

6. Length of time worked there prior to accident _____

7. Type of work being done at time of injury _____

8. In you own words, please describe accident _____

9. Have you been treated by another doctor for this accident? () Yes () No

If yes, please list doctor's names and addresses _____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

10. Are you: () improved () unchanged () getting worse

11. What types of medications are you taking? _____

12. Have you had physical therapy help? () Yes () No If yes, how often

() Daily () Every other day () Several times a week () Weekly () Every other week () Monthly

() Other _____

Does the physical therapy help? () Yes () No () Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

() Yes () No () Don't know

If yes, describe: _____

Were these similar complaints the result of a previous accident(s)? () Yes () No

Please provide details of the accident(s) _____

WORK / COMP HISTORY

Date: ___/___/___

Patient _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthday _____ Sex _____ S/S# _____

Name of Compensation Carrier _____ Phone () _____

Address of Carrier _____ City _____ State _____ Zip _____

Employer's Name _____ Phone () _____

Employer's Address _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? () Yes () No

3. Previous Workers' Compensation Injury: () Yes () No

4. Accident reported to employer? () Yes () No Name of person reported accident to _____

5. Injured at _____ City _____ State _____ Zip _____

6. Length of time worked there prior to accident _____

7. Type of work being done at time of injury _____

8. In you own words, please describe accident _____

9. Have you been treated by another doctor for this accident? () Yes () No

If yes, please list doctor's names and addresses _____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

10. Are you: () improved () unchanged () getting worse

11. What types of medications are you taking? _____

12. Have you had physical therapy help? () Yes () No If yes, how often

() Daily () Every other day () Several times a week () Weekly () Every other week () Monthly

() Other _____

Does the physical therapy help? () Yes () No () Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

() Yes () No () Don't know

If yes, describe: _____

Were these similar complaints the result of a previous accident(s)? () Yes () No

Please provide details of the accident(s) _____

14. Have you had any other serious accidents which required medical care? () Yes () No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? () Yes () No

Describe: _____

16. Have you had any surgeries? () Yes () No

If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illnesses? () Yes () No

Have you had psychiatric care? () Yes () No

18. Have you received a medical discharge from the Armed Forces? () Yes () No

19. Have you returned to work since this accident? () Yes () No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL TIME PART TIME

CURRENT MEDICAL COMPLAINTS

Back Pain

1. Currently, I have pain in my: () low back () mid back () upper back

2. My pain began: () gradually () suddenly

3. I have pain: () sometimes () all of the time

4. My pain goes into my: () right leg () left leg () both

5. I have tingling and/or numbness in my: () right leg () left leg () both

6. My pain is worse when I:

cough and sneeze () Yes () No

sit () Yes () No

bend () Yes () No

walk () Yes () No

lift () Yes () No

push () Yes () No

pull () Yes () No

7. My back is worse with sexual activity () Yes () No

8. My pain wakes me up during the night () Yes () No

9. Changes in the weather affect my pain () Yes () No

Neck Pain:

- 1. My neck pain began: gradually suddenly
- 2. I have pain: sometimes all of the time
- 3. My pain goes into my: right arm left arm both
- 4. I have tingling and/or numbness in my right arm left arm both
- 5. My pain is worse when I:
 - cough and sneeze Yes No
 - beend forward Yes No
 - lift Yes No
 - push Yes No
 - pull Yes No
 - turn my head Yes No
- 6. My pain wakes me up during the night Yes No
- 7. Changes in the weather affect my pain Yes No
- 8. I have neck stiffness Yes No
- 9. I have headaches Yes No
- 10. If I do get headaches, they occur sometimes all of the time

Other Pain

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding you condition:

JOB DESCRIPTION

(In terms of an 8-hour workday, "occasional" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8 hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities

	Not at all	Occasionally	Frequently	Continuously
Bend / stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing / Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job, I lift:	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	()	()	()	()
11 to 24 pounds	()	()	()	()
25 to 34 pounds	()	()	()	()
35 to 50 pounds	()	()	()	()
51 to 74 pounds	()	()	()	()
75 to 100 pounds	()	()	()	()

4. Do you have to bend over while doing lifting? () Yes () No

5. Are your feet used for repetitive movements, such as in operating foot controls? () Yes () No

6. Do you use your hands for repetitive actions, such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right Hand	() Yes () No	() Yes () No	() Yes () No
Left Hand	() Yes () No	() Yes () No	() Yes () No

7. Are you required to work on unprotected heights? () Yes () No

Describe: _____

8. Are you required to be around moving machinery? () Yes () No

Describe: _____

9. Are you exposed to marked changes in temperature and humidity? () Yes () No

Describe: _____

10. Are you required to drive automotive equipment? () Yes () No

Describe: _____

11. Are you exposed to dust, fumes and/or gases? () Yes () No

Describe: _____

12. Please list any additional comments: _____

Signature: _____

Date: ___/___/___