Midtown Medical

Date_____

Patient Name_____ Patient Account Number_____

INJURY DATE AND LOCATION

Date of Injury: City/Town:

Intersection: Route/Highway:

YOUR POSITION IN AUTOMOBILE ACCIDENT

Were you: ☐ Driver ☐ Front seat passenger ☐ Backseat passenger ☐ Other_____

YOUR VEHICLE

Year, Make, Model: _____

Your estimated speed at the moment of the accident _____mph. ☐ Stopped ☐ Slowing ☐ Accelerating

Point of impact to your vehicle: ☐ Front ☐ Back ☐ Left ☐ Right ☐ Other:_____

Was the impact to your vehicle? ☐ Light ☐ Moderate ☐ Heavy Damage estimate $_____

AUTOMOBILE ACCIDENT DESCRIPTION

Please describe how the accident happened: _____

Did accident happen while you were on job? ☐ Yes ☐ No

Name of person driving the vehicle (if other than patient) _____

OTHER VEHICLE

Year, Make, Model: _____

Their estimated speed at the moment of the accident _____mph. ☐ Stopped ☐ Slowing ☐ Accelerating

Were there any other vehicles involved? ☐ Yes ☐ No

If yes, please describe: _____

SEAT BELTS AND AIRBAGS

Were you wearing a seatbelt? ☐ Yes ☐ No

Did your air bag deploy? ☐ Yes ☐ No Did your seat break or bend? ☐ Yes ☐ No

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AT THE TIME OF IMPACT

Which way was your body pointed at the time of impact? ☐ Straight ☐ Right ☐ Left

Which way was your head pointed at the time of impact? ☐ Straight ☐ Right ☐ Left

Were you leaning forward at the time of impact? ☐ Yes ☐ No

Did you brace before impact or were you relaxed? ☐ Relaxed ☐ Braced - **Against What?**_____

Did any body part of yours strike anything within the vehicle at the time of impact? ☐ Yes ☐ No

If "YES", specify what part of your body struck what: (i.e. head, chest, left shoulder, right knee, etc.)

☐ Steering Wheel _____ ☐ Windshield _____ ☐ Dashboard _____

☐ Left Side Door _____ ☐ Right Side Door_____ ☐ Roof _____

☐ Left Window _____ ☐ Right Window _____ ☐ Other _____

Immediately following the accident, how did you feel? (Circle all that apply)

Dizzy Dazed Weak Upset Disoriented Nervous Nauseous Other:_____

Did you lose consciousness? ☐ Yes ☐ No For how long? _____

Were you able to get out of the vehicle on your own? ☐ Yes ☐ No

TREATMENT AT THE SCENE OF THE ACCIDENT

Did an ambulance come to the scene of the accident? ☐ Yes ☐ No

If yes, did you receive treatment at the scene of the accident? ☐ Yes ☐ No

What kind of treatment? _____

TREATMENT AT THE HOSPITAL

Were you transported to the hospital? ☐ Yes ☐ No If yes, which hospital? _____

How did you get there? ☐ Ambulance ☐ Police ☐ Private Transportation

Were you admitted? ☐ Yes ☐ No If yes, how long? _____

What treatment was given at the hospital? (check all that apply)

☐ None
☐ Pain Medication
☐ Muscle Relaxants
☐ Cervical/Neck Collar
☐ Instructed Regarding Concussion
☐ Instructed to call an Orthopedist/Neurologist
☐ CAT Scan/MRI
☐ X-rays
☐ Stitches
☐ Bandaged
☐ Physical Therapy
☐ Instructed Regarding Sprains & Strains
☐ Instructed to call a Private Physician
☐ Other: _____

OTHER DOCTORS

Have you seen any other Doctors for your injuries prior to coming to our office? ☐ Yes ☐ No

If yes, who and what did they do for you? _____

_____

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CHIEF COMPLAINTS

Please "X" any complaints that you have been experiencing since your accident. Do not fill in the area "For Doctor Use Only".

FOR DOCTOR USE ONLY

"X"	COMPLAINTS	LOCATION				ONSET	VAS	DESCRIPTION / REMARKS
	NECK PAIN	LF	RT	MID	BILAT			
	JAW PAIN	LF	RT	BILAT				
	UPPER BACK PAIN	LF	RT	MID	BILAT			
	MID BACK PAIN	LF	RT	MID	BILAT			
	SHOULDER PAIN	LF	RT	BILAT				
	ARM / WRIST PAIN	LF	RT	BILAT				
	HAND / FINGER PAIN	LF	RT	BILAT				
	LOW BACK PAIN	LF	RT	MID	BILAT			
	HIP PAIN	LF	RT	BILAT				
	LEG / KNEE PAIN	LF	RT	BILAT				
	ANKLE / FOOT / TOES	LF	RT	BILAT				
	NUMBNESS / TINGLING	LF	RT	BILAT	↑ ↓			
	RADIATING PAIN	LF	RT	BILAT	↑ ↓			
	HEADACHES	LF	RT	FRONT	OCC			Duration: Freq:

OTHER COMPLAINTS

Please "X" any complaints that you have been experiencing since your accident.

FOR DOCTOR USE ONLY

	Anxiety	**Doctors Notes**
	When I am traveling in a vehicle	
	When someone else is driving and I do not feel in control	
	When another vehicle is following too close to me	
	When I get near the scene of where the accident occurred	
	Other:	
	Difficulty Sleeping	
	Because of pain and discomfort	
	Nlightmares about the accident	
	Other:	
	Please indicate the number of hours you are able to sleep at night:	
	Depression	
	What do you feel is causing you to be depressed?	
	Memory Loss	
	Concentration	
	Other	

Patient Name: _____ Date: _____

DUTIES UNDER DURESS

Are there day to day activities which are painful or difficult for you to perform as a result of your injuries?

☑ Check all those that apply & write in the reason why you have difficulty performing the activity.

FOR DOCTOR USE

☐ **Work**	**Reason for the difficulty**	**Duration**

☐ **Studies/School**	**Reason for the difficulty**	**Duration**

	Domestic Duties	**Reason for the difficulty**	**Duration**
☐	Vacuuming		
☐	Taking care of children		
☐	Dishes/Dusting/Laundry		
☐	Preparing meals		
☐	Personal Care/bathing, dressing		
☐	Other		
☐	Other		

	Household Duties	**Reason for the difficulty**	**Duration**
☐	Mowing/Yard work		
☐	Transporting family		
☐	Shopping		
☐	Taking out trash		
☐	Other		
☐	Other		

LOSS OF ENJOYMENT

Are there areas of your life which you normally would be enjoying but are currently not enjoying, as a result of your injuries?

	Hobbies/Recreation	**Reason for the difficulty**	**Duration**
☐	Jogging		
☐	Dancing		
☐	Shopping		
☐	Traveling		
☐	Working Out		
☐	Other		
☐	Other		

	Sports	**Reason for the difficulty**	**Duration**
☐	Social		
☐	Competitive		
☐	Other		
☐	Other		

	Sexual Relations	**Reason for the difficulty**	**Duration**
☐	Other		
☐	Other		
☐	Other		