

Motor Vehicle Accident History Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Vehicles Involved:

Your Vehicle - Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Other Vehicle - Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Accident Type:  Rear ended  Head-on  Broad-sided

Appraised Damage to Your Vehicle: \$ \_\_\_\_\_

Appraised Damage to Other Vehicle: \$ \_\_\_\_\_

Describe Accident: \_\_\_\_\_

Specifics of Accident (Mark each that applies to the accident):

- Were you on the job at the time of the accident ( ) Yes ( ) No
• Your were the  Driver  Passenger
 Front seat  Back seat
• Impending Collision  Aware  Unaware
 Braced  Not braced
• Head struck object  Yes  No
List object \_\_\_\_\_  Broken Glass
• Did you experience  Black out  Loss of Consciousness
 Flash of Light Seen Upon Impact
 Dizziness / Lightheaded
 Dazed / Confused

# of Air bag(s) Deployed \_\_\_\_\_ location \_\_\_\_\_

Describe your emotional state Immediately following the accident:

\_\_\_\_\_

Describe your emotional state after the first few days:

\_\_\_\_\_

- In relation to the back of your head, was your headrest set: Low / Middle / High
• Where was your head facing at the time of accident? Left / Forward / Right
• Were you rendered unconscious as a result of the accident? Yes / No
• Did you feel pain immediately after the accident? Yes / No
If no, when did you first notice pain? \_\_\_\_\_

List ALL your areas of complaint from greatest to least.

- 1. \_\_\_\_\_ 6. \_\_\_\_\_
2. \_\_\_\_\_ 7. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Immediate Event Following the Accident

- Ambulance – Paramedics Called
 Treated at Scene
 Transported to Hospital by Ambulance
 Went to Hospital on their Own
 X-rays, MRI, CT Scan performed at Hospital
 Treatment at Hospital
 Medication Prescribed (List all meds on page 3)
 Follow-up Recommended

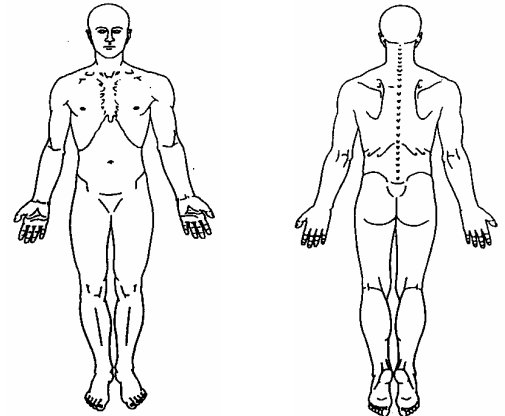
Other Doctors/Healthcare Practitioners Seen:  NO

- Orthopedist  Neurologist
 Psychiatrist  Physical Therapist
 Counselor  Chiropractor
 Obstetrician  Massage Therapist
 Family Physician

Treatment Rendered:

- NONE
 Cervical Collar  Brace, area \_\_\_\_\_
 Home Traction  TENS
 Hospitalization / #days \_\_\_\_\_
 Bed Rest  Immobilization

Please indicate areas of pain On figures below.



Precision Sport & Spine

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

• Have you suffered from anxiety or depression as a result of this trauma / motor vehicle accident?  
**YES**    **NO** (if yes, explain & list any medications prescribed for anxiety/depression) \_\_\_\_\_

• Are you/have you received counseling for anxiety/depression?  No     Yes – (explain) \_\_\_\_\_

• Have you been prescribed any medication as a result of your injures sustained? **YES** **NO**

Name of meds: \_\_\_\_\_

Symptoms Related to Neck Trauma – (if symptoms have subsided – document approximately date they subsided)

• **Did you experience any visual disturbances at any time?**     No     Yes – (Indicate when)  
[ ] Immediately after impact    [ ] A few hours after impact    [ ] Next day    Other \_\_\_\_\_  
Do you still suffer from this symptom – Yes / No – If no list approximate date it stopped: \_\_\_\_\_

• **Did you experience any dizziness/light headiness?**     No     Yes – (Indicate when)  
[ ] Immediately after impact    [ ] A few hours after impact    [ ] Next day    Other \_\_\_\_\_  
Do you still suffer from this symptom – Yes / No – If no list approximate date it stopped: \_\_\_\_\_

• **Did you experience any ringing or buzzing in the ears?**     No     Yes – (Indicate when)  
[ ] Immediately after impact    [ ] A few hours after impact    [ ] Next day    Other \_\_\_\_\_  
Do you still suffer from this symptom – Yes / No – If no list approximate date it stopped: \_\_\_\_\_

• **Have you noticed any Pain/Clicking/Popping in your Jaw (TMJ)?**     No     Yes – (Indicate when)  
[ ] Immediately after impact    [ ] A few hours after impact    [ ] Next day    Other \_\_\_\_\_  
Do you still suffer from this symptom – Yes / No – If no list approximate date it stopped: \_\_\_\_\_

• **Have you experienced any Headaches since the trauma?**     No     Yes (Indicate when)  
[ ] Immediately after impact    [ ] A few hours after impact    [ ] Next day    Other \_\_\_\_\_  
Do you still suffer from this symptom – Yes / No – If no list approximate date it stopped: \_\_\_\_\_

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Patient Name: \_\_\_\_\_

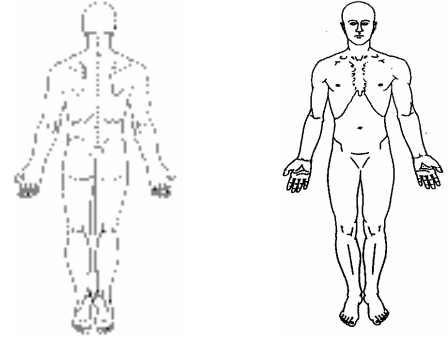
Date: \_\_\_\_\_

**Chief Complaint #1:** Neck / Low Back / Mid-Back - Other: \_\_\_\_\_

• Mark **Area of Discomfort** on Drawing ----->

• When did the **last episode** of your symptom appear?  
\_\_\_\_\_

• Did anything **contribute to the onset** of your condition?  
\_\_\_\_\_  
\_\_\_\_\_



• Is your condition getting progressively worse, better or same? \_\_\_\_\_

• Is your condition worse in the A.M / P.M. / All the Time / Doesn't Apply? \_\_\_\_\_

• **Interferes** with Work / Seep / Daily Routine / Other: \_\_\_\_\_

• **Describe** your Discomfort: Sharp with Movement / Sharp when Not Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling – Other: \_\_\_\_\_

• Does your discomfort **radiate or travel** (For example: from neck to shoulder)? If so where: \_\_\_\_\_

• **Rate the severity** of your discomfort (1 = minimal and 10 = severe pain) Now: \_\_\_\_\_ At its worst: \_\_\_\_\_

• **How many days** out of an average week do you have pain? \_\_\_\_\_

**What percentage** of the time do you feel your discomfort?      0-25%      26-50%      51-75%      76-100%

• **Activities** or movements that are painful or **aggravate** your condition: Sitting / Standing / Walking / Bending / Lying Down Getting Dressed / Sports / Work / Hobbies (please list) / Everything - Other: \_\_\_\_\_

• What **activities**, movements, make your condition **feel better**? \_\_\_\_\_

• Have you had the **exact same condition**? Yes / No If so when? \_\_\_\_\_

List other Physicians or Therapist seen for this condition in chronological order from most recent:

Physician	Date	Outcome of Visit (diagnostic test, treatment, diagnosis)
_____	_____	_____
_____	_____	_____
_____	_____	_____

• List treatments you have received for this condition:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Ultrasound             | <input type="checkbox"/> Body Mechanics Training      | <input type="checkbox"/> Chiropractic     | <input type="checkbox"/> Surgery               |
| <input type="checkbox"/> Massage                | <input type="checkbox"/> Strengthening Exercises      | <input type="checkbox"/> Osteopathic Care | <input type="checkbox"/> Trigger Point Inject. |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Aerobics                     | <input type="checkbox"/> Acupuncture      | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> TENS Unit              | <input type="checkbox"/> Gravity Inversion – Traction | <input type="checkbox"/> Naturopathy      |  |
| <input type="checkbox"/> Bed Rest               | <input type="checkbox"/> Biofeedback                  | <input type="checkbox"/> Back Brace       |  |

Additional Notes (For Office Use) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Chief Complaint # 2** : Neck / Low Back / Mid-Back - Other: \_\_\_\_\_

• Mark **Area of Discomfort** on Drawing ----->

• When did the **last episode** of your symptom appear?

\_\_\_\_\_

• Did anything **contribute to the onset** of your condition?

\_\_\_\_\_

• Is your condition getting progressively worse, better or same? \_\_\_\_\_

• Is your condition worse in the A.M / P.M. / All the Time / Doesn't Apply? \_\_\_\_\_

• **Interferes** with Work / Seep / Daily Routine / Other: \_\_\_\_\_

• **Describe** your Discomfort: Sharp with Movement / Sharp when Not Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling – Other: \_\_\_\_\_

• Does your discomfort **radiate or travel** (For example: from neck to shoulder)? If so where: \_\_\_\_\_

• **Rate the severity** of your discomfort (1 = minimal and 10 = severe pain) Now: \_\_\_\_\_ At its worst: \_\_\_\_\_

• **How many days** out of an average week do your have pain? \_\_\_\_\_

**What percentage** of the time do you feel your discomfort?      0-25%      26-50%      51-75%      76-100%

• **Activities** or movements that are painful or **aggravate** your condition: Sitting / Standing / Walking / Bending / Lying Down Getting Dressed / Sports / Work / Hobbies (please list) / Everything - Other: \_\_\_\_\_

• What **activities, movements, make your condition feel better?** \_\_\_\_\_

• Have you had the **exact same condition?** Yes / No If so when? \_\_\_\_\_

List other Physicians or Therapist seen for this condition in chronological order from most recent:

Physician	Date	Outcome of Visit (diagnostic test, treatment, diagnosis)
_____	_____	_____
_____	_____	_____
_____	_____	_____

• List treatments you have received for this condition:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Ultrasound             | <input type="checkbox"/> Body Mechanics Training      | <input type="checkbox"/> Chiropractic     | <input type="checkbox"/> Surgery               |
| <input type="checkbox"/> Massage                | <input type="checkbox"/> Strengthening Exercises      | <input type="checkbox"/> Osteopathic Care | <input type="checkbox"/> Trigger Point Inject. |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Aerobics                     | <input type="checkbox"/> Acupuncture      | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> TENS Unit              | <input type="checkbox"/> Gravity Inversion – Traction | <input type="checkbox"/> Naturopathy      |  |
| <input type="checkbox"/> Bed Rest               | <input type="checkbox"/> Biofeedback                  | <input type="checkbox"/> Back Brace       |  |

Additional Notes (For Office Use) \_\_\_\_\_

\_\_\_\_\_

## Precision Sport & Spine

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Chief Complaint # 3:** Neck / Low Back / Mid-Back - Other: \_\_\_\_\_

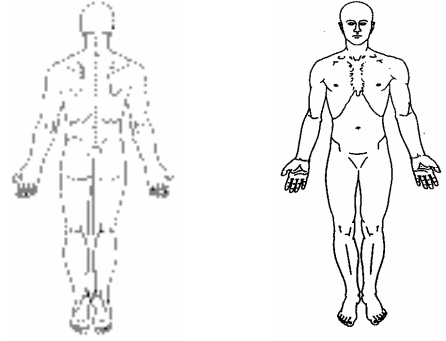
• Mark **Area of Discomfort** on Drawing ----->

• When did the **last episode** of your symptom appear?

\_\_\_\_\_

• Did anything **contribute to the onset** of your condition?

\_\_\_\_\_  
\_\_\_\_\_



• Is your condition getting progressively worse, better or same? \_\_\_\_\_

• Is your condition worse in the A.M / P.M. / All the Time / Doesn't Apply? \_\_\_\_\_

• **Interferes** with Work / Seep / Daily Routine / Other: \_\_\_\_\_

• **Describe** your Discomfort: Sharp with Movement / Sharp when Not Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling – Other: \_\_\_\_\_

• Does your discomfort **radiate or travel** (For example: from neck to shoulder)? If so where: \_\_\_\_\_

• **Rate the severity** of your discomfort (1 = minimal and 10 = severe pain) Now: \_\_\_\_\_ At its worst: \_\_\_\_\_

• **How many days** out of an average week do you have pain? \_\_\_\_\_

**What percentage** of the time do you feel your discomfort?      0-25%      26-50%      51-75%      76-100%

• **Activities** or movements that are painful or **aggravate** your condition: Sitting / Standing / Walking / Bending / Lying Down Getting Dressed / Sports / Work / Hobbies (please list) / Everything - Other: \_\_\_\_\_

• What **activities, movements, make your condition feel better?** \_\_\_\_\_

• Have you had the **exact same condition?** Yes / No If so when? \_\_\_\_\_

List other Physicians or Therapist seen for this condition in chronological order from most recent:

Physician	Date	Outcome of Visit (diagnostic test, treatment, diagnosis)
_____	_____	_____
_____	_____	_____
_____	_____	_____

• List treatments you have received for this condition:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Ultrasound             | <input type="checkbox"/> Body Mechanics Training      | <input type="checkbox"/> Chiropractic     | <input type="checkbox"/> Surgery               |
| <input type="checkbox"/> Massage                | <input type="checkbox"/> Strengthening Exercises      | <input type="checkbox"/> Osteopathic Care | <input type="checkbox"/> Trigger Point Inject. |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Aerobics                     | <input type="checkbox"/> Acupuncture      | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> TENS Unit              | <input type="checkbox"/> Gravity Inversion – Traction | <input type="checkbox"/> Naturopathy      |  |
| <input type="checkbox"/> Bed Rest               | <input type="checkbox"/> Biofeedback                  | <input type="checkbox"/> Back Brace       |  |

Additional Notes (For Office Use) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Precision Sport & Spine

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Chief Complaint #4:** Neck / Low Back / Mid-Back - Other: \_\_\_\_\_

• Mark **Area of Discomfort** on Drawing ----->

• When did the **last episode** of your symptom appear?

\_\_\_\_\_

• Did anything **contribute to the onset** of your condition?

\_\_\_\_\_

• Is your condition getting progressively worse, better or same? \_\_\_\_\_

• Is your condition worse in the A.M / P.M. / All the Time / Doesn't Apply? \_\_\_\_\_

• **Interferes** with Work / Seep / Daily Routine / Other: \_\_\_\_\_

• **Describe** your Discomfort: Sharp with Movement / Sharp when Not Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling – Other: \_\_\_\_\_

• Does your discomfort **radiate or travel** (For example: from neck to shoulder)? If so where: \_\_\_\_\_

• **Rate the severity** of your discomfort (1 = minimal and 10 = severe pain) Now: \_\_\_\_\_ At its worst: \_\_\_\_\_

• **How many days** out of an average week do you have pain? \_\_\_\_\_

**What percentage** of the time do you feel your discomfort?      0-25%      26-50%      51-75%      76-100%

• **Activities** or movements that are painful or **aggravate** your condition: Sitting / Standing / Walking / Bending / Lying Down Getting Dressed / Sports / Work / Hobbies (please list) / Everything - Other: \_\_\_\_\_

• What **activities, movements, make your condition feel better?** \_\_\_\_\_

• Have you had the **exact same condition?** Yes / No If so when? \_\_\_\_\_

List other Physicians or Therapist seen for this condition in chronological order from most recent:

Physician	Date	Outcome of Visit (diagnostic test, treatment, diagnosis)
_____	_____	_____
_____	_____	_____
_____	_____	_____

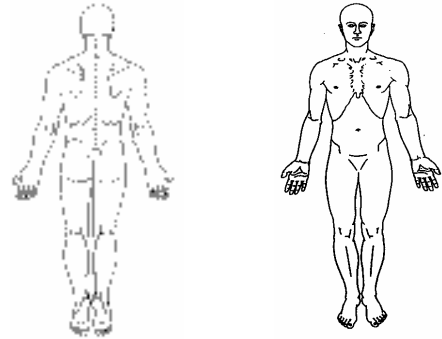
• List treatments you have received for this condition:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Ultrasound             | <input type="checkbox"/> Body Mechanics Training      | <input type="checkbox"/> Chiropractic     | <input type="checkbox"/> Surgery               |
| <input type="checkbox"/> Massage                | <input type="checkbox"/> Strengthening Exercises      | <input type="checkbox"/> Osteopathic Care | <input type="checkbox"/> Trigger Point Inject. |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Aerobics                     | <input type="checkbox"/> Acupuncture      | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> TENS Unit              | <input type="checkbox"/> Gravity Inversion – Traction | <input type="checkbox"/> Naturopathy      |  |
| <input type="checkbox"/> Bed Rest               | <input type="checkbox"/> Biofeedback                  | <input type="checkbox"/> Back Brace       |  |

Additional Notes (For Office Use) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Precision Sport & Spine

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social History

- Single
- Married
- Divorced
- Smoker
- Non-Smoker
- Drinks Alcohol
- Does not drink Alcohol
- Takes Drugs

List your Hobbies

\_\_\_\_\_  
\_\_\_\_\_

Water: \_\_\_\_\_ cups /oz per day Caffeine: \_\_\_\_\_ cups / sodas per day

Sleep Pattern

How many hours of uninterrupted sleep do you experience? \_\_\_\_\_ Hours

How is your sleep? ( Circle: restful, restless, hard to get to sleep, wake up often )

Exercise

What kind of exercise do you do? \_\_\_\_\_

How often? \_\_\_\_\_ How long at a time? \_\_\_\_\_

Occupational History

Job Title \_\_\_\_\_ Job Demands \_\_\_\_\_

Occupation Demands:

Sitting \_\_\_\_\_ Hours per day

Standing \_\_\_\_\_ Hours per day

Walking \_\_\_\_\_ Hours per day

Lifting \_\_\_\_\_ Hours per day

Stress Level

Rate your stress level from 1-10 ( 10 being the highest and 1 the lowest stress level )

\_\_\_\_\_ / 10

What is the main reason for your stress level? \_\_\_\_\_

Medications/Traumas

Please list medications you are taking:

\_\_\_\_\_  
\_\_\_\_\_

Vitamins or Herbs:

\_\_\_\_\_

Injuries / Surgeries you have had. *Please give description and approximate date*

Motor Vehicle Accidents:

\_\_\_\_\_

Any Falls:

\_\_\_\_\_

Head Injuries:

\_\_\_\_\_

Broken Bones:

\_\_\_\_\_

Surgeries or Hospitalization: (State approximate dates)

\_\_\_\_\_

serious injuries or health problems:

\_\_\_\_\_

## Precision Sport & Spine

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Medical Conditions – List any current or previous condition(s):** (List approximate date of previous condition)

**Medical Condition      Previously      Currently**

Heart Attack/Stroke      \_\_\_\_\_      [   ]  
 High Blood Pressure      \_\_\_\_\_      [   ]  
 Other Heart Condition      \_\_\_\_\_      [   ]  
 Fainting/Seizures      \_\_\_\_\_      [   ]  
 Easy Bruising / Bleeding      \_\_\_\_\_      [   ]

\_\_\_\_\_  
 Difficulty Breathing      \_\_\_\_\_      [   ]  
 Chest Pain/Tightness      \_\_\_\_\_      [   ]  
 Coughing Up Blood      \_\_\_\_\_      [   ]  
 Persistent Cough      \_\_\_\_\_      [   ]  
 Emphysema/COPD      \_\_\_\_\_      [   ]  
 Asthma      \_\_\_\_\_      [   ]

\_\_\_\_\_  
 Excessive Fatigue      \_\_\_\_\_      [   ]  
 Difficulty Sleeping      \_\_\_\_\_      [   ]  
 Unusual Stress at Work      \_\_\_\_\_      [   ]  
 Unusual Stress at Home      \_\_\_\_\_      [   ]  
 Anxiety      \_\_\_\_\_      [   ]  
 Depression      \_\_\_\_\_      [   ]  
 Irritability

\_\_\_\_\_  
 Unexplained Fever      \_\_\_\_\_      [   ]  
 Night Sweats      \_\_\_\_\_      [   ]  
 Weight Loss 10 lbs or more \_\_\_\_\_      [   ]  
 Loss of Appetite      \_\_\_\_\_      [   ]  
 Lumps in neck, armpit, groin \_\_\_\_\_      [   ]  
 Cancer      \_\_\_\_\_      [   ]

\_\_\_\_\_  
 Stomach Pain      \_\_\_\_\_      [   ]  
 Persistent Diarrhea      \_\_\_\_\_      [   ]  
 Excessive Constipation      \_\_\_\_\_      [   ]  
 Dark Black Stools      \_\_\_\_\_      [   ]  
 Blood in Stools      \_\_\_\_\_      [   ]  
 Colitis      \_\_\_\_\_      [   ]  
 Ulcers      \_\_\_\_\_      [   ]

**Medical Condition      Previously      Currently**

Do you have a bowel movement daily? Yes No  
 How many days do you skip between bowel movements when you are not regular? \_\_\_\_\_ days  
     • How often does this occur? \_\_\_\_\_

\_\_\_\_\_  
 Frequent Neck Pain      \_\_\_\_\_      [   ]  
 Jaw Pain      \_\_\_\_\_      [   ]  
 Severe, Frequent Headaches \_\_\_\_\_      [   ]  
 Shoulder Pain      \_\_\_\_\_      [   ]  
 Wrist Pain or Carpel Tunnel \_\_\_\_\_      [   ]  
 Hip Pain      \_\_\_\_\_      [   ]  
 Low Back Pain      \_\_\_\_\_      [   ]  
 Knee Pain      \_\_\_\_\_      [   ]  
 Ankle Pain      \_\_\_\_\_      [   ]  
 Feet Pain      \_\_\_\_\_      [   ]  
 Artificial Bones/Joints      \_\_\_\_\_      [   ]

\_\_\_\_\_  
 Pain when urinating      \_\_\_\_\_      [   ]  
 Difficulty urinating      \_\_\_\_\_      [   ]  
 Blood in Urine      \_\_\_\_\_      [   ]  
 Need to Urinate at Night      \_\_\_\_\_      [   ]

\_\_\_\_\_  
 Hepatitis      \_\_\_\_\_      [   ]  
 Kidney Problems      \_\_\_\_\_      [   ]  
 HIV Positive, AIDS      \_\_\_\_\_      [   ]  
 Diabetes      \_\_\_\_\_      [   ]  
 Gout      \_\_\_\_\_      [   ]

**Females Only**

Vaginal Bleeding      \_\_\_\_\_      [   ]  
 Other than Period      \_\_\_\_\_      [   ]  
 Painful Menstrual Period \_\_\_\_\_      [   ]  
 Back Pain with \_\_\_\_\_      [   ]  
 Menstrual Period

Other Menstrual Problems: \_\_\_\_\_