THE wellnessconnection

111 O'Fallon Commons Drive ~ O'Fallon, MO 63368
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Auto Accident Intake

Personal History

Date: _____

Full Name: _____ Preferred Name: _____
Address: _____ City: _____
State /Prov: _____ Zip/Postal Code: _____ Preferred Language: _____
Home Phone: _____ Birth Date: _____ Age: _____
Cell Phone: _____ Sex: [ ] Male [ ] Female
Social Security # _____ Circle One: Married Single Divorced Widowed
E-mail Address:_____
Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other/ I Decline to Answer
Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer
Business Employer: _____ Type of Work: _____
Business Phone: _____ Name of Spouse: _____
Spouse's Employer:_____
Type of Work: _____ Names and Ages of Children:_____
Name and Number of Emergency Contact: _____ Relationship: _____

Current Health History

Purpose of this Appointment: _____
Other Doctors seen for this condition: [ ] Yes [ ] No Who?:_____
Type of Treatment: _____ Results: _____
Are you currently taking any medications? [ ] Yes [ ] No
Medication Name & Dosage/Frequency

_____
_____
_____

Do you have any medication allergies? [ ] Yes [ ] No
Medication Name / Reaction / Onset Date / Comment

_____
_____

Do You Wear a Shoe Lift / Insert? [ ] Yes [ ] No
Do You Suffer From Any Other Condition *Other Than* That Which You Are Now Consulting Us?:_____
Name of Your Primary Care Provider?:_____ Office Phone #:_____

Lifestyle

Do you exercise? [ ]Yes [ ]No How often? (circle) 1X 2X 3X 4X 5X /per week Other: _____
What activities? [ ]Running [ ]Jogging [ ]Weight Training [ ]Cycling [ ]Yoga [ ]Pilates [ ]Swimming
[ ]Other _____
Smoking Status: [ ]Every Day Smoker [ ]Occasional Smoker [ ]Former Smoker [ ]Never Smoked
Do you drink alcohol? [ ]Yes [ ]No How much / week?_____
Do you drink coffee? [ ]Yes [ ]No How many cups / day?_____
Do you take any supplements (i.e. vitamins, minerals, herbs)? _____
Blood Pressure: [ ] Normal [ ] Low [ ] High
Weight: _____
Height: _____

Date and time of accident:_____ AM____ PM____
Were you the: Driver_____ Front Passenger_____ Rear Passenger_____
Make and model of the vehicle you were occupying?_____
If a traffic violation was issued, to whom was it issued?_____
Number of people in your vehicle?_____
Did the police come to the accident site? Yes_____ No_____
Was a police report filed? Yes_____ No_____
Were there any witnesses? Yes_____ No_____
Were you wearing a seat belt? Yes_____ No_____
Was this vehicle equipped with airbags? Yes_____ No_____
If yes, did it/they inflate? Yes_____ No_____
In relation to the base of your skull, where was the headset?
Above____ Below____ At base of skull____
What did your vehicle hit upon impact? Another vehicle_____ Other____
If other, explain:_____
Did any part of your body strike anything in the vehicle? Yes_____ No_____
If yes, please describe:_____
Make and model of the other vehicle(s) involved? _____
Name of the location/street on which you were traveling? _____
In which direction were you headed? N___ S___ E___ W___
What was the approx. speed of your vehicle? _____
Did the impact to your vehicle come from the:
Front____ Rear____ R-Side____ L-Side____ Other____
During the impact, were you facing: Right____ Left____ Forward____
Were you _____ aware or _____ surprised by the impact?
If in the accident the vehicle made impact with another vehicle:
Direction other vehicle was headed? N___ S___ E___ W___
Approximate speed of the other vehicle? _____
In your own words, please describe the accident:
_____
_____
_____
_____
_____

Indicate your degree of comfort while performing the following activities:

Lying on back:	_____Comfortable	_____Uncomfortable	_____Painful
Lying on side:	_____Comfortable	_____Uncomfortable	_____Painful
Lying on stomach:	_____Comfortable	_____Uncomfortable	_____Painful
Sitting:	_____Comfortable	_____Uncomfortable	_____Painful
Standing:	_____Comfortable	_____Uncomfortable	_____Painful
Stretching:	_____Comfortable	_____Uncomfortable	_____Painful
Lovemaking:	_____Comfortable	_____Uncomfortable	_____Painful
Walking:	_____Comfortable	_____Uncomfortable	_____Painful
Running:	_____Comfortable	_____Uncomfortable	_____Painful
Sports:	_____Comfortable	_____Uncomfortable	_____Painful
Working:	_____Comfortable	_____Uncomfortable	_____Painful
Lifting:	_____Comfortable	_____Uncomfortable	_____Painful
Bending:	_____Comfortable	_____Uncomfortable	_____Painful
Kneeling:	_____Comfortable	_____Uncomfortable	_____Painful
Pulling:	_____Comfortable	_____Uncomfortable	_____Painful
Reaching:	_____Comfortable	_____Uncomfortable	_____Painful

Have you retained an attorney: ____Yes ____ No

If yes, whom? _____

His/Her phone #: _____

Recovery

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform:

____ Standing	____ Twisting
____ Sitting	____ Crawling
____ Walking	____ Bending
____ Lifting	____ Operating equipment
____ Driving	____ Work with arms above head
____ Lifting	____ Other

If other, please describe:_____

What positions can you work in with minimum physical effort and for how long?
_____ N/A_____

Prior to the injury were you capable of working on an equal basis with others your age?
____ Yes ____ No ____ N/A

Do you work with others who can help you with any heavy lifting?
____ Yes ____ No ____ N/A

While in recovery, is there any light duty work you could request?
____ Yes ____ No ____ N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred on your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Your auto insurance company's name (even if another party is at fault):
_____Claim #_____

Name of auto insurance company of the party that hit you:
_____Claim #_____

Signature_____ Date ____/____/____
____ Adult Patient ____ Parent or Guardian ____ Spouse