PRECISION
SPINAL CARE

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MECHANISM OF INJURY

Today's Date: _____

Patient's Name _____ **Patient #** _____

Date of Accident _____ **Location** _____

○ **Auto** ○ **Work** ○ **Slip and Fall** ○ **Other:** _____

You were: ○ **In a car** ○ **A pedestrian** ○ **On a motorcycle** ○ **On a bicycle** ○ **Other** _____

You were struck from: ○ **Behind** ○ **Right passenger side** ○ **Left Driver's side** ○ **Front (head on)** ○ **Other** _____

Your car at the time of the accident: ○ **Parked** ○ **In traffic, but stopped** ○ **Moving at approximately what speed** _____

Other car at the time of the accident: ○ **Parked** ○ **In traffic, but stopped** ○ **Moving at approximately what speed** _____

What type of car were you in: Year _____ **Make** _____ **Model** _____

What type of car impacted your vehicle: Year _____ **Make** _____ **Model** _____

Were there any other impacts to your car after the initial impact: ○ **Hit a 3rd vehicle** ○ **Stationary object** ○ **Other** _____

At the time of impact were brakes applied: ○ **Yes** ○ **No**

Damage to your vehicle: ○ **None** ○ **Minor** ○ **Moderate** ○ **Severe** ○ **Totaled**

Damage to other vehicle: ○ **None** ○ **Minor** ○ **Moderate** ○ **Severe** ○ **Totaled**

Do you have current transportation: ○ **Yes** ○ **No**

What was your position in the car at the time of the accident: ○ **Driver** ○ **Passenger front seat** ○ **Back seat behind driver** ○ **Back seat behind passenger seat** ○ **Other** _____

At the time of impact were you: ○ **Braced** ○ **Hit by surprise**

Were any joints locked out at impact: ○ **Foot on brake** ○ **Arms locked out on steering wheel** ○ **Other** _____

What was your head/neck position at the time of impact: ○ **Looking straight ahead** ○ **Turned to the right** ○ **Turned to the left** ○ **Looking up** ○ **Looking down** ○ **Other** _____

Did you hit your head on any object: ○ **No** ○ **Steering Wheel** ○ **Dash** ○ **Windshield** ○ **Headrest** ○ **Other** _____

At impact, did your head and neck get jerked back and forth (whiplash)? ○ **Yes** ○ **No** ○ **Other** _____

Did you have any lacerations or bruising? ○ **Yes** ○ **No** **If yes, where:** _____

PLEASE COMPLETE NEXT PAGE

What was the position of the headrest: ○ Below the level of my head ○ At the level of my head ○ Close enough to stop my head from backward motion ○ Angled to far back to stop my head from moving backward

Were you wearing a seat belt/lap restraint: ○ Yes ○ No Was the airbag deployed: ○ Yes ○ No

Were you knocked out unconscious at all after impact: ○ Yes If so, for how long: _____ ○ No ○ Unsure

Road Conditions: ○ Dry ○ Wet ○ Icy Do you have a police report: ○ Yes ○ No

Was it ○ Light ○ Dark If night was there adequate lighting: ○ Yes ○ No

Who was cited at fault: ○ Other driver ○ Driver of your car ○ Neither

Did you seek treatment the same day as the accident: ○ Yes ○ No

Taken by: ○ Ambulance ○ Self ○ Other: _____

Did you get examined by a medical provider after the accident: ○ Yes ○ No

WORK RELATED IMPACT

Are you working? ○ Yes: _____ Full time _____ Part time ○ No

Days lost from work: _____

Work restrictions: ○ Standing ○ Driving ○ Walking ○ Lifting ○ Sitting ○ Typing/computer

○ Other (please explain) _____

_____

Work disability status: ○ None ○ Partial/Light Duty ○ Total

Gaps in care (beyond 2 weeks): ○ Self medicated over the counter ○ Self treated hot/cold packs ○ Altered lifestyle ○ Altered work ○ Financial hardship

Please explain any gaps in treatment: _____

_____

_____

PRE-EXISTING CONDITIONS:

Were you actively under any treatment program prior to the accident: ○ Yes ○ No If yes, explain: _____

_____

Please describe your general health condition prior to the accident: _____

_____

_____

PLEASE COMPLETE NEXT PAGE

Did you have any previous: ○ MVA'S ○ Work Injuries ○ Other injuries If so, when: _____

Symptoms: _____

Treatment Provided: _____

Date Released _____

○ Resolved ○ Ongoing problems (please describe): _____

Do you have open claims on any prior accidents: ○ Yes ○ No

Do you have any previous disability ratings: ○ Yes ○ No

Have you had prior spinal surgery: ○ Yes ○ No If yes, where: _____

FOR OFFICE USE ONLY

You have listed _____ as your symptoms, are they:

○ New and did not exist prior to the accident

○ Had similar symptoms recently before the accident, but the accident made them:
○ mildly worse ○ moderately worse ○ severely worse

_____

_____

Describe any exams or treatment provided to you prior to consulting our office:

Doctor/Facility: _____

Images taken: _____

Treatment prescribed: _____

_____ Images/radiology reports/medical notes requested

_____ Images reviewed _____ radiology report in file _____ medical notes in file

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Pictures of vehicle damage: ○ Yes ○ No Doctor viewed pictures _____ (Date)

Pre-existing assessment:

	Pre-accident serverity/freq/ ADL	Post-accident serverity/freq/ADL
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Notes: _____

_____

_____

_____

_____