PATIENT INFORMATION

Name _____ Today's Date _____
Date of Birth_____Height_____Weight_____Dominant Hand? R L
Address_____
City_____State_____Zip_____
email_____DL#_____
Phone (home)_____Phone (other)_____

Health Insurance Company_____Policy#_____
Address_____City_____State_____Zip_____
Adjuster _____Phone_____
Car Insurance Company_____
Address_____City_____State_____Zip_____
Adjuster _____Phone_____
Agent_____Phone_____
Policy #_____Claim #_____
What Medical Payments Coverage?_____What Uninsured Motorist Coverage?_____
What Law Firm Represents You?_____
Address_____City_____State_____Zip_____
Your Lawyer's Name?_____Phone_____

Name of Insured on your Car Policy_____
Date of Loss/Accident?_____Date you first saw any Doctor after accident_____
Cost of all medical treatment since the accident? $_____
How much income have you lost since the accident? $_____
What is the property damage (repair amount) of your car? $_____

Name of your personal M.D._____Phone_____
Address_____City_____State_____Zip_____

NameType	Phone#	Amount of Bill	For office use only

Write any Ambulance, Hospital, M.D. Chiropractor, Dentist, Acupuncturist, PT, etc., since accident

Please use other side of page to write additional doctors & hospitals

Orange County Wellness Auto Accident Mechanism of Injury and Patient History Form

Name_____ Date_____
DOB_____ Height_____ Weight_____ Dominant Hand? R L
Address_____
Phone_____ Cell_____
Email_____ DL#_____
Date of Accident_____ Time of Accident_____ AM/PM
Please Describe how the accident happened _____
_____
_____
_____
_____
_____

- Were you wearing your seatbelt? Y N
- Did you seat break or bend? Y N
- What was your position in the car? Driver Front Passenger Left Rear Right Rear
- What type and year of vehicle were you in?_____
- If "Driver", were your hands on the steering wheel? Both Left Right
- Where was your head facing at the time of impact? Straight Left Right Behind
- What approximate speed of you vehicle when the collision occured?_____mph
- What type of vehicle struck yours?_____
- What approximate speed of the other vehicle when the collision occured?_____mph
- Were you surprised by the impact? Y N If "No", how did you brace yourself? Hands Feet
- What was the angle of impact to your vehicle? Front Back Left Right
- Did Your vehicle strike another vehicle? Y N
- If Yes- angle of impact? Front Back Left Right
- Did Air Bags Deploy? Y N
- Where you leaning forward at the time of the accident? Y N
- Were you rendered unconscious or "black out" as a result of the collision? Y N
- What motions did your body moved during the impact?

  Back to Forth Forward to back Side to Side Rotated to right Rotation to left
- Did you strike anything in the vehicle at the time of impact? Y N
- If yes please state what part of your body was impacted- Head, chest, chin, shoulders, arm, leg.
- What part of the car did your body impact? Steering wheel, windshield, dashboard, left side door, left window, windsheid, roof, right side door, right window, other_____
- Did your heart hit the headrest? Y N If yes, where was your headrest set? Low Middle High

- Did you feel pain immediately after the accident? Y N if so, where- Neck, shoulder, elbow, wrist, mid back, low back hip, knee, ankle. Or other_____
- Immediately following the collision, how did you feel? Dizzy, Dazed, Weak, Upset, Disoriented, Confused, Nervous, Nauseous, Vomiting, Ringing in the ears, Other _____
- Did the Police respond to the accident? Y N
- Did the ambulance or fire department respond to the accident? Y N
- Were you extracted from the vehicle? Y N
- Were you treated at the scene? Y N
- Were you transported to the hospital? Y N What Hospital?_____
- What was done at the hospital? X-rays, CT, MRO, Stitches, Medications_____
- Have you been involved in a motor accident before? Y N
    - Year_____ Body areas injured_____
    - Treatment? Y N Describe treatment_____
    - Injury Resolved? Y N Residual Symptoms? Y N MRI? Y N
    - Year_____ Body areas injured_____
    - Treatment? Y N Describe treatment_____
    - Injury Resolved? Y N Residual Symptoms? Y N MRI? Y N
    - Year_____ Body areas injured_____
    - Treatment? Y N Describe treatment_____
    - Injury Resolved? Y N Residual Symptoms? Y N MRI? Y N

Please list any and all past injuries or traumas: _____
_____
_____
_____
_____
_____

Please describe any pre-injury symptoms in the body parts in which you currently have symptoms:_____
_____
_____
_____
_____

Please list any past surgeries even if unrelated to present injuries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any medication (both other-the-counter and prescription) you are currently taking:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

□ Do you have any WEAKNESS in any of the Following:

Weakness:	□ Shoulder Left	□ Shoulder Right
	□ Elbow Left	□ Elbow Right
	□ Wrist Left	□ Wrist Right
	□ Hand Left	□ Hand Right
	□ Hips Left	□ Hips Right
	□ Knees Left	□ Knees Right
	□ Ankle Left	□ Angle Right
	□ Feet Left	□ Feet Right

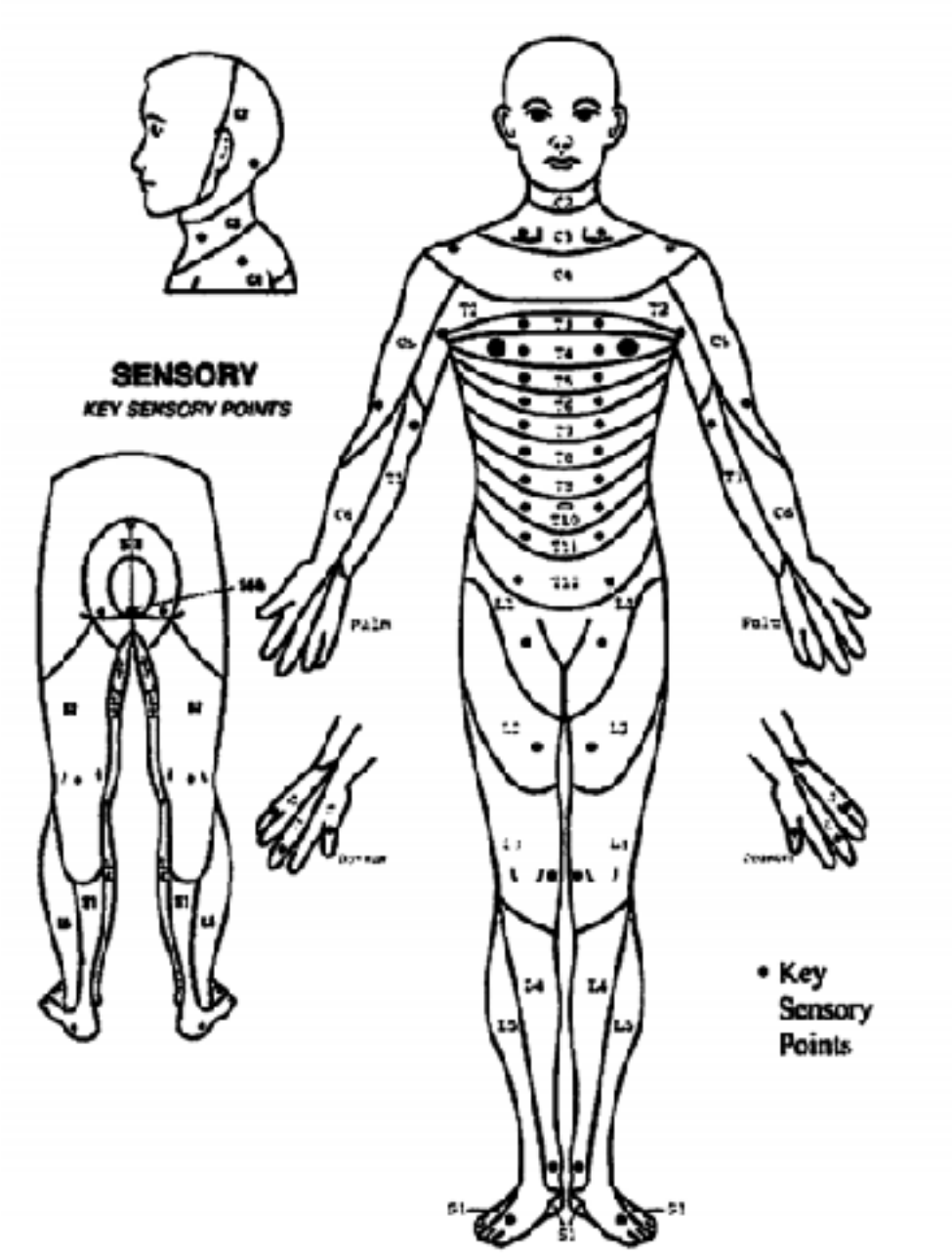
Percent of time you have this: □ 25% □ 50% □ 75% □ 100% □ Other_____%

Please shade in all areas where you have had RADIATING PAIN (Pain that Travel's or Shooting Pain) in the past 7 days

Radiating Pain is: □ Sharp L R □ Dull L R □ Ache L R □ Other _____

Percent of time you have this: □ 25% □ 50% □ 75% □ 100% □ Other____%

RIGHT LEFT

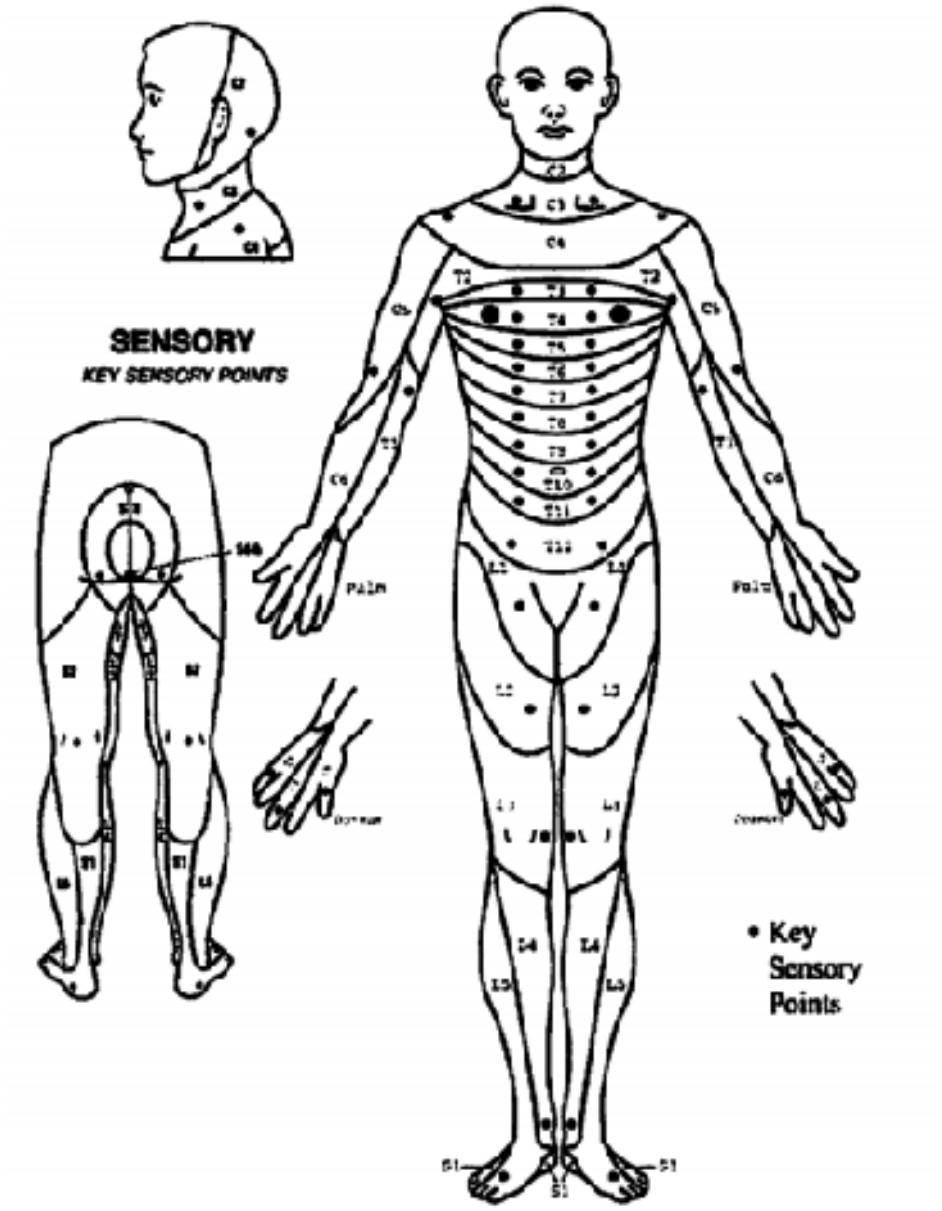


Shade in all areas of ALTERED SENSATION (i.e. Pins/Needles, Numbness, Tingling)

□ Pins/Needles L R □ Tingling L R □ Numbness L R □ Other _____

Percent of time you have this: □ 25% □ 50% □ 75% □ 100% □ Other____%

RIGHT **LEFT**



_____ _____

Patient or Guardian Signature Date

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

<u>Orthopedic & Musculoskeletal Symptoms</u>

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/ Scrape to _____
- ☐ Other Symptoms _____
- ☐ Other Symptoms _____

<u>Neurological Symptoms</u>

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

<u>Symptoms Associated with Injuries</u>

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ I am taking over-the-counter pain meds

<u>Brain/Neuropsych/MTBI Symptoms</u>

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/ Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Changes in Sense of Taste or Smell
- ☐ Depression
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing