AUTO / WORK RELATED ACCIDENT

one

ABOUT YOU

Today's Date: ___/___/___ File #: ________________

Name: ________________________________

two a

AUTO RELATED ACCIDENT

Date & Time of Accident: ______________ ❑ a.m. ❑ p.m.
Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger
If a traffic violation was issued, to whom was it issued?

____

Number of people in accident 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 your 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 headrest? . . . . ❑ Above ❑ Below ❑ At base of skull
What did your vehicle 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 & model of the vehicle you were occupying?

____

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 ❑ Right Side ❑ Left Side ❑ Other
During impact, were you facing: ❑ Right ❑ Left ❑ Forward
Were you ❑ aware or ❑ surprised by the impact?
If accident vehicle made impact with another vehicle...
Make and model of that other vehicle? ________________

____

Direction other vehicle was headed? ❑ N ❑ S ❑ E ❑ W

Speed of the other vehicle? ________________

In your words, please describe the accident: ________________

____

____

____

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WORK RELATED ACCIDENT

Date & Time of Accident: ______________ ❑ a.m. ❑ p.m.
Was your accident directly related to your work?
❑ Yes ❑ No
Briefly describe the events that occurred just before and during your accident: ________________

____

____

Give the address where accident occurred: (if other than employer's address) ________________

____

Was anyone else present during your accident?
❑ Yes ❑ No
Did you report your accident to your employer?
❑ Yes ❑ No
What recommendations did your employer make just after your accident? ________________

____

Has this type of accident happened to you before?
❑ Yes ❑ No
To the best of your knowledge, has this accident occurred in your workplace before? . . . . ❑ Yes ❑ No
In general:
Is your job physically stressful? . . . . ❑ Yes ❑ No
Is your job mentally stressful? . . . . ❑ Yes ❑ No
Is your workplace noisy? . . . . ❑ Yes ❑ No
Have you changed jobs in the last year? ❑ Yes ❑ No

PLEASE CONTINUE ON BACK

three

AFTER INJURY

Did accident render you unconscious? . . . . . ❑ Yes ❑ No

If yes, for how long? ____

Please describe how you felt immediately after the accident:

____

____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No

When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of Hospital and/or Attending doctor: ____

____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: ____

____

Were X-rays taken? . . . . ❑ Yes ❑ No

Was medication prescribed? . . . . ❑ Yes ❑ No

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

Indicate ☑ the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other ____

Is your condition getting worse?

❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Indicate your degree of comfort while performing the following activities:

Activity	Comfortable	Uncomfortable (even if only sometimes)	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Have you retained an attorney: ❑ Yes ❑ No

If yes, whom: ____

His/Her Phone #: ____

four

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? ____

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

❑ Standing	❑ Driving	❑ Operating equipment
❑ Sitting	❑ Twisting	❑ Work with arms above head
❑ Walking	❑ Crawling	❑ Typing
❑ Lifting	❑ Bending	❑ Stooping

❑ Other ____

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

five

ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: ____

Co. Name: ____

Address: ____

Phone #: ____

Insured's Name: ____

Policy #: ____ Claim #: ____

Insured's SS #: ____ D.O.B. __/__/__

Insured's Employer: ____

Agent's Name: ____

If any of your medical or account information has changed, please inform our front desk personnel.
Please remember you are ultimately responsible for your account.

____ SIGNATURE   __/__/__ DATE

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PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

Patient Name ______________________ **Date** ______________________

1. When did your symptoms start: ______________________ **Describe your symptoms and how they began:**

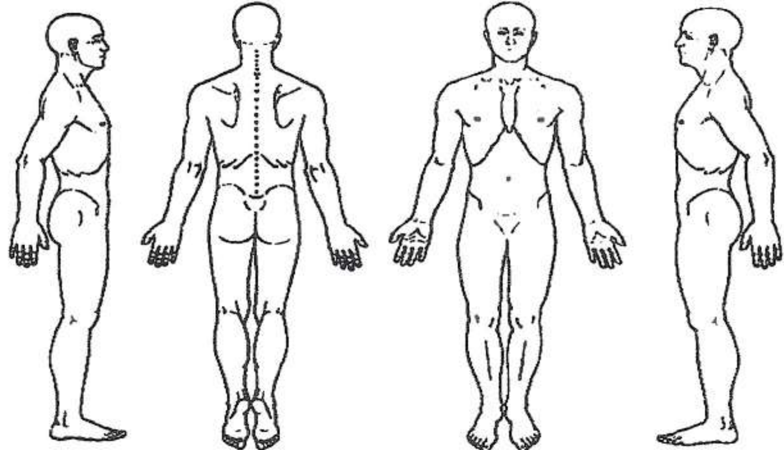
____

____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse: ______________________

8. What activities make your symptoms better: ______________________

9. Who have you seen for your symptoms?

① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. When and what treatment? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* __________ ③ CT Scan *date:* __________
② MRI *date:* __________ ④ Other *date:* __________

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

11. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature ______________________ **Date** ______________________