

3. If a CAT Scan was performed, of what body part(s)?

- Head, Neck, Other, Upper / Mid Back, Lower Back, Chest / Rib Cage, Abdomen

4. If a MRI was performed, of what body part(s)?

- Head, Neck, Other, Upper / Mid Back, Lower Back, Chest / Rib Cage, Abdomen

5. What was the diagnosis given at the hospital?

a. Head

- Concussion, Contusions, Skull Fracture, Other, Lacerations

b. Jaw

- Strain, Fracture, Contusions, Sprain, Whiplash, Other, Dislocation, Lacerations

c. Neck

- Strain, Fracture, Lacerations, Other, Sprain, Whiplash, Contusions, Dislocation, Disc Injury

d. Upper / Middle Back

- Strain, Fracture, Contusions, Other, Sprain, Disc Injury, Dislocation, Lacerations

e. Lower Back

- Strain, Fracture, Contusions, Other, Sprain, Disc Injury, Dislocation, Lacerations

f. Pelvis

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

g. Chest / Rib Cage

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

h. Abdomen

- Strain, Other, Lacerations, Contusions

i. Shoulders

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

j. Arms

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

k. Elbows

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

l. Forearms

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

m. Wrists

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

n. Hands / Fingers

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

o. Buttocks

- Strain, Contusions, Sprain, Other, Lacerations

p. Hips

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

q. Thighs

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

r. Knees

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

s. Legs

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

t. Ankles

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

u. Feet / Toes

- Strain, Fracture, Other, Sprain, Lacerations, Dislocation, Contusions

v. Other

- Strain, Fracture, Sprain, Lacerations, Dislocation, Contusions

w. Describe any additional diagnosis given:

Text input field for additional diagnosis

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

- Oral Medication Sutures Splint Collar
- Injection Ice Packs Cast Support
- Topical Antiseptics Hot Packs Brace Surgery
- Bandages Other

7. Instructions Given When Discharged From Hospital

a. Were you told to see?

- General Practitioner Chiropractor Neurologist
- Physical Therapist Orthopedist Internist
- General Surgeon Plastic Surgeon
- Other

b. What recommendations were made?

- No Further Care No Follow-up Instructions Observation
- Rest Ice Heat Collar Support
- Time Off Work Other

c. Were medications prescribed?

- Pain Anti-inflammatory Antibiotic Nervousness
- Other

E. FOLLOWING THE ACCIDENT / INJURY

1. How much later did additional symptoms develop?

- Immediately Hours That Evening Next Morning
- Days Week Month

2. What additional symptoms developed?

a. Head

- Pain Stiffness Numbness Tingling
- Other

b. Jaw

- Pain Stiffness Numbness Tingling
- Other

c. Neck

- Pain Stiffness Numbness Tingling
- Other

d. Upper / Middle Back

- Pain Stiffness Numbness Tingling
- Other

e. Lower Back

- Pain Stiffness Numbness Tingling
- Other

f. Pelvis

- Pain Stiffness Numbness Tingling
- Other

g. Chest / Rib Cage

- Pain Stiffness Numbness Tingling
- Other

h. Abdomen

- Pain Stiffness Numbness Tingling
- Other

i. Shoulders

- Pain Stiffness Numbness Tingling
- Other

j. Arms

- Pain Stiffness Numbness Tingling
- Other

k. Elbows

- Pain Stiffness Numbness Tingling
- Other

l. Forearms

- Pain Stiffness Numbness Tingling
- Other

m. Wrists

- Pain Stiffness Numbness Tingling
- Other

n. Hands / Fingers

- Pain Stiffness Numbness Tingling
- Other

o. Buttocks

- Pain Stiffness Numbness Tingling
- Other

p. Hips

- Pain Stiffness Numbness Tingling
- Other

q. Thighs

- Pain Stiffness Numbness Tingling
- Other

r. Knees

- Pain Stiffness Numbness Tingling
- Other

s. Legs

- Pain Stiffness Numbness Tingling
- Other

t. Ankles

- Pain Stiffness Numbness Tingling
- Other

u. Feet / Toes

- Pain Stiffness Numbness Tingling
- Other

v. Other

3. Since your accident / injury have you suffered from?

- Blurred Vision Chest Pain Nausea
- Double Vision Difficulty Breathing Vomiting
- Reduced Vision Palpitations Frequent Urination
- Impaired Hearing Constipation Inability To Hold Urine
- Ringing In Ears Diarrhea Painful Urination

E. ACCIDENT/INJURY (Continued)

4. Additionally have you experienced any of the following?

- Anxiety
- Depression
- Mood Swings
- Nervousness
- Poor Memory
- Tension
- Other _____
- Convulsions
- Dizziness
- Headaches
- Fainting
- Loss Of Balance
- Fatigue
- Restlessness
- Insomnia
- Light Sensitivity
- Reduced Appetite
- Weakness
- Weight Gain
- Weight Loss

5. Are you restricted in any of the following areas as a

- Daily Living
- Occupational/Work
- Recreational Activities
- Other _____

6. Have you missed work due to this accident / injury?

- Missed No Work
- Missed Work From: _____ To: _____
- Limited Work Activity
- Other _____

7. Did you self treat your symptoms?

- Ice
- Heat
- Bed Rest
- Over-The-Counter Medication
- Other _____

8. Did you seek medical care elsewhere?

a. General Practitioner Name: _____

Diagnosis And Treatment Recommendation:

b. Internist Name: _____

Diagnosis And Treatment Recommendation:

c. Chiropractor Name: _____

Diagnosis And Treatment Recommendation:

d. Neurologist Name: _____

Diagnosis And Treatment Recommendation:

e. Orthopedist Name: _____

Diagnosis And Treatment Recommendation:

f. General Surgeon Name: _____

Diagnosis And Treatment Recommendation:

g. Plastic Surgeon Name: _____

Diagnosis And Treatment Recommendation:

h. Psychologist Name: _____

Diagnosis And Treatment Recommendation:

i. Other Name: _____ Type: _____

Diagnosis And Treatment Recommendation:

9. Have you had any of the following tests?

- CT Scan
- MRI
- Electrodiagnostic Studies
- Other _____

10. What is the reason for seeking today's consultation?

- Persisting Complaints
- Worsening Of Symptoms
- Other _____

F. INSURANCE / ATTORNEY INFORMATION

	Yes	No
1. Have you contacted an insurance adjuster or representative regarding this claim?	<input type="checkbox"/>	<input type="checkbox"/>
Company: _____		
Adjuster: _____		
Claim #: _____		

2. Have you engaged services of an attorney?	<input type="checkbox"/>	<input type="checkbox"/>
Attorney: _____		
Address: _____		
City: _____ State: _____ Zip: _____		
Phone: _____		

3. Have you filed an accident / injury report?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you filed for insurance benefits?	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Or Guardian Signature: _____ **Date:** _____

PLEASE MAKE NO MARKS IN THIS AREA

