LEMONT ACTIVE CHIRO

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PATIENT NAME: _____

DETAILS

DATE OF SERVICE: _____

☐ **INITIAL EVALUATION**
☐ **FOLLOW-UP EVALUATION**
☐ **FINAL EVALUATION**

TYPE OF ACCIDENT:
☐ AUTOMOBILE
☐ WORKERS COMPENSATION
☐ SLIP AND FALL

IN HIS/HER OWN WORDS, THE PATIENT DESCRIBES THE ACCIDENT/HISTORY OF PRESENT ILLNESS:

_____

_____

DATE OF ACCIDENT: _____

THE PATIENT'S POSITION WAS:
☐ DRIVER
☐ FRONT PASSENGER
☐ LEFT REAR PASSENGER
☐ RIGHT REAR PASSENGER
☐ MIDDLE FRONT PASSENGER
☐ MIDDLE REAR PASSENGER

TIME OF THE ACCIDENT: ____:____ AM/PM

LOCATION OF ACCIDENT: _____

PATIENT'S VEHICLE SPEED: _____ MPH

OTHER VEHICLE SPEED: _____ MPH

DAMAGE TO PATIENT'S VEHICLE:
☐ MILD
☐ MODERATE
☐ EXTENSIVE
☐ TOTALED

VISIBILITY:
☐ POOR
☐ FAIR
☐ GOOD

THE WEATHER WAS: ☐ SNOWING ☐ RAINING ☐ WINDY ☐ FOGGY ☐ CLEAR

WHO HIT WHO/WHAT:
☐ PATIENT HIT OTHER VEHICLE
☐ OTHER VEHICLE HIT PATIENT
☐ PATIENT HIT OTHER OBJECT

POINT OF IMPACT: ☐ FRONT ☐ LEFT FRONT ☐ RIGHT FRONT ☐ REAR ☐ LEFT REAR ☐ RIGHT REAR ☐ LEFT SIDE ☐ RIGHT SIDE

WAS THE PATIENT USING THE SEATBELT? ☐ YES ☐ NO

WAS THE PATIENT USING THE SHOULDER HARNESS? ☐ YES ☐ NO

DOES THE VEHICLE HAVE AN AIRBAG? ☐ YES ☐ NO

WAS THE AIRBAG DEPLOYED? ☐ YES ☐ NO

DID THE PATIENT STRIKE ANYTHING ON THE VEHICLE? ☐ YES ☐ NO

IF YES, WHAT? ☐ WHEEL ☐ WINDSHIELD ☐ ARMREST ☐ DASHBOARD ☐ SIDE DOOR ☐ SIDE WINDOW ☐ AIRBAG

WHERE? (PART OF THE BODY): _____

DID THE PATIENT SEE THE ACCIDENT COMING? ☐ YES ☐ NO

DOES THE VEHICLE HAVE HEADREST? ☐ YES ☐ NO

WHAT POSITION?
☐ EVEN WITH TOP OF HEAD
☐ EVEN WITH BOTTOM OF HEAD
☐ MIDDLE OF NECK

WAS THE PATIENT BRACED FOR THE IMPACT? ☐ YES ☐ NO

WAS THE PATIENT DAZED? ☐ YES ☐ NO

DID THE PATIENT LOSE CONSCIOUSNESS? ☐ YES ☐ NO

IF YES, FOR HOW LONG? _____

DIRECTION OF HEAD:
☐ FACING FORWARD
☐ FACING LEFT
☐ FACING RIGHT

WAS THE HEAD INJURED? ☐ YES ☐ NO

OTHER PART INJURED: _____

IMMEDIATELY AFTER THE ACCIDENT, PATIENT EXPERIENCED:
☐ HEADACHES ☐ NECK PAIN ☐ LOW BACK PAIN
OTHER: _____

DID THE PATIENT GO TO THE HOSPITAL? ☐ YES ☐ NO

WHAT HOSPITAL: _____

TRANSPORTATION TO HOSPITAL BY:
☐ AMBULANCE
☐ DROVE SELF
☐ SOMEBODY ELSE
☐ POLICE

TEST DONE AT THE HOSPITAL:
☐ X-RAYS ☐ MRI ☐ CT-SCAN ☐ LAB WORK
OTHER TEST: _____

ANY PRIOR DOCTOR FOR THIS ACCIDENT? ☐ YES ☐ NO

NAME: DR. _____

TESTS PERFORMED _____

NAME 2: DR. _____

TESTS PERFORMED _____

NAME 3: DR. _____

TESTS PERFORMED _____

PATIENT NAME: _____

SINCE THE ACCIDENT IS THE PATIENT:
☐BETTER ☐SAME ☐WORSE

HAS THE PATIENT LOST TIME FROM WORK? ☐YES ☐NO

IF YES, FOR HOW LONG? _____

CAN PERFORM PHYSICAL WORK ACTIVITIES? ☐YES ☐NO

IF NO, WHY? ☐PAIN ☐WEAKNESS ☐STRESS

OTHER: _____

SINCE THE ACCIDENT HAS HAD PROBLEMS WITH:

☐SEEING ☐TASTING ☐SMELLING ☐EATING

☐HEARING ☐BATHING ☐GROOMING ☐DRESSING

☐READING ☐TYPING ☐WRITING ☐GRASPING

☐HOLDING ☐PINCHING ☐STANDING ☐LEANING

☐WALKING ☐STOOPING ☐SQUATTING ☐CLIMBING

☐KNEELING ☐BENDING ☐TWISTING ☐CARRYING

☐LIFTING ☐PUSHING ☐PULLING ☐REACHING

☐SITTING ☐DRIVING ☐RIDING CAR ☐PLANE TRAV.

☐SPORTS ☐EXERCISING ☐LOSS OF SEXUAL DRIVE

☐RECLINING ☐RESTFUL SLEEPING

☐INSOMNIA ☐USING THE TOILET

☐LOSS OF CONCENTRATION ☐NERVOUS ☐IRRITABLE

☐CHANGE IN PERSONALITY ☐TACTILE FEELING

CAN GO TO SLEEP WITHOUT PROBLEMS? ☐YES ☐NO

AWAKEN BECAUSE OF PAIN? ☐YES ☐NO

IF YES, WHERE? _____

HAD SLEEP PROBLEMS BEFORE? ☐YES ☐NO

PATIENT'S OCCUPATION: _____

DUTY: ☐LIGHT DUTY
☐REGULAR DUTY

FINANCIAL BURDEN FOR PATIENT AND FAMILY? ☐YES ☐NO

IF YES, PATIENT EXPLAINS: _____

_____

HAS BEEN IN AN ACCIDENT BEFORE? ☐YES ☐NO

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. ☐YES ☐NO

DETAILS: _____

_____

ANY RESIDUAL PROBLEMS? ☐YES ☐NO

EXPLAIN: _____

_____

SECOND ACCIDENT

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. _____

DETAILS: _____

_____

ANY RESIDUAL PROBLEMS? ☐YES ☐NO

EXPLAIN: _____

_____

THIRD ACCIDENT

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. _____

DETAILS: _____

_____

ANY RESIDUAL PROBLEMS? ☐YES ☐NO

EXPLAIN: _____

_____