Full Name:		——— Birth	Date:	— Gender: M F
Address:	City	/:	State	:: Zip:
Home Phone:	— Work phone: —		Cell Phone: -	
SSN#: —	Marital Status: S M	W D Sep S	Spouses name: ——	
Insurance Info: Policy Holder:		– Policy #: ——		
Claim #: —				
Description of Accident: ent	er a full description of the	accident, injury or	onset in the space belo	ow.
Date & time of accident: —	am/pm Place	of accident: Street		
City, ST:				
2. Your condition during and in	mmediately after injur	v/onset: enter the	details of your conditi	ion during and after
your injury or onset in the space be	_	j, onsett enter the		

1. Your vehicle type	2. Your position in vo	ehicle	3. Wha	at your vehicle	e doing at time of t	he accider	nt?
Car Station wagon Van Pickup Truck Bus Large Truck Other	Driver Front pas Left rear Middle re Right rear Other	ear		turn Rt / Lt ling along	ion / in traffic / at Parked Slowing Dow Other	'n	_
4. Time / Speed / Damage	5. Details of Acciden	t	6. Roa	d Conditions			
Time of accident: mph Other vehicle speed mph	Visibility at time of acciden		Icy	litions at the tim Wet Sar	ndy Dark	Clear and	dry
Damage to your vehicle Mild Moderate Totaled	You hit other vehicle Other vehicle hit you You hit (Object):		Point of In Head-on Rear-en	npact 1 l	eft front r	ight front ight rear	_
7 Rody Position etc							
Did you see the accident coming?	Yes No	Does your	vehicle have	headrests?	Yes No		
Where you braced for impact?	Yes No	What was	the position of	of your headrest	s at time of impact?		
Did you have a seat belt on?	Yes No		top of head			iddle of neck	-
Did you have a shoulder harness on?	Yes No			-	time of impact?		
		Facing fo	rward	Turned to	the right Tu	irned to the le	eft
Did driver airbags deploy? Yes	No Did passenger airba	ags deploy?	Yes 1	No Did side	airbags deploy?	Yes No)
8 During the Accident		0	A 64 41	:-			
Did your body strike anything inside	your vehicle? Yes No				fter and a few days f		
If yes, describe:			eadache	Neck pain	Stiffness	Loss of	smell
Did you loose consciousness?	Yes N		zziness	Mid back pai		Loss of	taste
If yes, how long?		Na	ausea	Low back pa		Ringing	g in ears
			inting	Chest pain	Depression	Diarrhe	
Your vehicle's estimated damage?			onfusion	Cold hands	Irritability	Constip	oation
Damage to their vehicle: Mild	Moderate Totaled	-	ımbness	Cold feet	Chest pain	Fatigue	
Did the police show up a			in behind eye		_	eping probl	
Was an accident report fi			her:	os onorme.	ss of oreasti	sping proof	CIIIS
r							
10. Emergency room?		11	1. Treatmen	t history			
Where did you go after the accident? Nan	ne of Hospital	Fill in	any other doc	etor(s) seen prior t	o your first visit to this	office	
Home Work Hospi	tal ER Private Docto	r 1. Di	·				/
How did you get there?					X-rays done? Yes	s No	
Drove self Somebody else	Ambulance Police	* * *					
· · · · · · · · · · · · · · · · · · ·	b work done? Yes No		•	its?			No
Body part(s) x-rayed:					No Last visit:		
What lab work: Treatments: Cervical collar Ice					First visit date: /X-rays done? Yes		-
Medications?		-	-		A-rays done?		
Follow-up instructions:					Currently treating		No
· — —			-		No Last visit:		/

Clarksville Spine & Rehabilitation LLC

Dr. Joseph Rogers Dr. Rich Zupancic

815 Eastern Blvd. Clarksville, IN 47129 (812) 282-7500 (812) 282-4552

Description of Symptoms – (describe your symptoms in the sections below, in the order of severity, if possible)

Current Sympt	Current Symptom #1 (check off the boxes below to describe your first symptom. Describe only 1 symptom per section)								
7	ne body loc L R Front of head Top of head Back of head	B d		2. Types of pain Dull Sharp Cutting Aching Throbbing Burning Numbness Tingling Cramping Spasm Stinging Shooting Pounding Constricting Other:					
Jaw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other:		R R R R R R R R R R R R	B B B B B B B B B B B B B B B B B B B	3. Pain Frequency Up to 1/4 of time 1/2 to 3/4 of time Most all the time 4. Pain intensity (how it affects daily activity) doesn't affect Seriously affects Prevents activities 5. Does this radiate into other body parts? Left Right Both Head Neck Shoulder Arm Hand Hip Leg Foot 6. Actions affecting this pain Brings On Aggravates Relieves In the A.M. In the P.M. Bending Forward Bending Backward Bending Right Twisting Left Twisting Right Coughing Sneezing Straining Standing Sitting Lifting Cleaning Other Other					

Current Sympto	Current Symptom #2 (please describe only 1 symptom per section)								
1. Check only one Headache Fro To Ba Jaw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand	e body loc L R ont of head ck of head ck of head L L L L L L L L L L L L L L L L L L L	ation b B d R R R R R R R R R R R R	B B B B B B B B B B B B B B B B B B B	2. Types of pain Dull Sharp Cutting Numbness Tingling Cramping Pounding Constricting Other: 3. Pain Frequency Up to 1/4 of time 1/4 to 1/2 of time 1/2 to 3/4 of time Most all the time 4. Pain intensity (how it affects daily activity) doesn't affect Somewhat affects Seriously affects Prevents activities 5. Does this radiate into other body parts? Left Right Both Head Neck Shoulder Arm Aching Spasm 6. Actions aff In the A.M In the P.M. Bending Forms Bending B. Bending B. Bending R. Twisting L. Twisting R. Coughing Sneezing Straining Standing	orward ackward eft ight	Burning Shooting gravates Relieves			
Hip Leg	L L	R R	B B	Hand Sitting Hip Lifting					
Foot Other:	L	R	B —	Leg Cleaning Foot Other					

Current Sympto	om #3	(plea	ase de	scribe only 1 symptom per section)
1. Check only on Headache Fr		ation b B	elow	2. Types of pain Dull Sharp Cutting Numbness Tingling Cramping Pounding Constricting Other: 3. Pain Frequency Up to 1/4 of time 1/2 to 3/4 of time Most all the time 4. Pain intensity (how it affects daily activity) doesn't affect Seriously affects Frevents activities 5. Does this radiate into other body parts? Left Right Both Head Aching Throbbing Burning Spasm Stinging Shooting 6. Actions affecting this pain Brings On Aggravates Relieves In the A.M. In the P.M. Bending Forward Bending Backward Bending Left Bending Right Twisting Left Twisting Right Coughing
Upper Arm Forearm Hand Hip Leg Foot Other:	L L L L L	R R R R R	B B B B B	Neck Shoulder Arm Hand Hip Leg Foot Sneezing Straining Standing Standing Lifting Lifting Cleaning Other Other

Current Sympton	Current Symptom #4 (please describe only 1 symptom per section)								
Top Back	R of head of head k of head	B d l d		2. Types of pain Dull Sharp Cutting Numbness Tingling Cramping Pounding Constricting Other:	Aching Throbbing Burning Spasm Stinging Shooting				
Jaw Eye Neck Upper Back	L L L L	R R R	B B B	3. Pain Frequency Up to 1/4 of time 1/2 to 3/4 of time Most all the time	6. Actions affecting this pain Brings On Aggravates Relieves In the A.M. In the P.M.				
Mid Back Low Back Chest	L L L	R R R	B B B	4. Pain intensity (how it affects daily activity) doesn't affect Somewhat affects Seriously affects Prevents	Bending Forward Bending Backward Bending Left				
Abdomen Ribs Buttocks Shoulder	L L L L	R R R	B B B	5. Does this radiate into other body parts? Left Right Both Head	Bending Right Twisting Left Twisting Right Coughing				
Upper Arm Forearm Hand	L L L	R R R	B B B	Neck Shoulder Arm	Sneezing Straining Standing				
Hip Leg Foot Other:	L L L	R R R	B B B	Hand Hip Leg Foot	Sitting Lifting Cleaning Other				
			_						

Current Sympto	om #5	(plea	ase de	scribe only 1 symptom per section)
1. Check only or Headache		ation b B	elow	2. Types of pain Dull Sharp Cutting Numbness Tingling Cramping Pounding Constricting Other: 3. Pain Frequency Up to 1/4 of time 1/4 to 1/2 of time 1/2 to 3/4 of time Most all the time 4. Pain intensity (how it affects daily activity) doesn't affect Seriously affects Prevents activities 5. Does this radiate into other body parts? Left Right Both Head Neck Shoulder Arm Hand Hip 2. Types of pain Aching Throbbing Burning Spasm Stinging Shooting Aching Throbbing Burning Spasm Stinging Shooting 6. Actions affecting this pain Brings On Aggravates Relieves In the A.M. In the P.M. Bending Forward Bending Backward Bending Right Twisting Left Twisting Right Coughing Sneezing Straining Straining Straining Sitting Lifting
Leg Foot Other: ———	L L	R R	В В	Leg Cleaning Foot Other

1. Check only one	body loc	ation b	elow	2. Types of pain				
Fro To	Ront of head op of head ck of head	[Dull Sharp Numbness Tinglir Pounding Constr		Aching Spasm	Throbbing Stinging	Burning Shooting
Jaw Eye Neck Upper Back	L L L L L	R R R R	B B B	3. Pain Frequency Up to 1/4 of time 1/2 to 3/4 of time	1/4 to 1/2 of time Most all the time	6. Actions affe In the A.M. In the P.M.		Aggravates Relieve
Mid Back Low Back Chest Abdomen	L L L L	R R R	B B B	Pain intensity (how it after doesn't affect Seriously affects activities	Somewhat affects	Bending For Bending Bac Bending Let Bending Rig	ckward ft	
Ribs Buttocks Shoulder Upper Arm Forearm	L L L L	R R R R	B B B B	5. Does this radiate into oth Left Head Neck Shoulder		Twisting Le Twisting Rig Coughing Sneezing Straining	ft	
Hand Hip Leg Foot Other:	L L L L	R R R R	B B B	Arm Hand Hip Leg Foot		Standing Standing Sitting Lifting Cleaning Other		

1. Check only one	-		elow	2. Types of pain					
From To	L R ont of head op of head			Dull Numbness Pounding	Sharp Tingling Constrict	Cutting Cramping ing Other:	Aching Spasm	Throbbing Stinging	Burning Shooting
Jaw Eye Neck	ck of head L L L L	R R R R	B B B	3. Pain Frequency Up to 1/4 of tin 1/2 to 3/4 of tin	ne	1/4 to 1/2 of time Most all the time	6. Actions affecting In the A.M. In the P.M.	C 1	Aggravates Relieves
Upper Back Mid Back Low Back Chest	L L L L	R R R	B B B	4. Pain intensity (I doesn't affect Seriously affect		ts daily activity) Somewhat affects Prevents	Bending For Bending Bac Bending Lef Bending Rig	ckward t	
Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot	L L L L L L L L	R R R R R R R	B B B B B B	activities 5. Does this radiat Head Neck Shoulder Arm Hand Hip Leg		body parts? ight Both	Twisting Let Twisting Rig Coughing Sneezing Straining Standing Sitting Lifting Cleaning	ft	

Current Symptom #8 (please describe only 1 symptom per section)								
1. Check only one bod Headache L Front of Top of Back of	R f head head head	ion be B	elow	2. Types of pain Dull Sharp Cutting Aching Throbbing Burning Numbness Tingling Cramping Spasm Stinging Shooting Pounding Constricting Other:				
Eye Neck Upper Back	L L L	R R R	B B B	3. Pain Frequency Up to 1/4 of time 1/2 to 3/4 of time Most all the time 6. Actions affecting this pain Brings On Aggravates Relieves In the A.M. In the P.M.				
Low Back	L	R R R	B B B	4. Pain intensity (how it affects daily activity) doesn't affect Seriously affects Prevents Bending Forward Bending Backward Bending Left Bending Right				
Ribs Buttocks	L	R R R	B B B	5. Does this radiate into other body parts? Left Right Both Head Twisting Left Twisting Right Coughing				
Forearm Hand	L L	R R R	B B B	Neck Sneezing Shoulder Straining Arm Standing				
Leg	L	R R R	В В В	Hand Sitting Hip Lifting Leg Cleaning Foot Other				