Clarksville Spine & Rehabilitation LLC

Dr. Joseph Rogers   Dr. Rich Zupancic

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

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 Spouses name: ________________

Insurance Info: Policy Holder: ________________ Policy #: ______________________

Claim #: ________________

1. Description of Accident: enter a full description of the accident, injury or onset in the space below.

Date & time of accident: __________ ________am/pm Place of accident: Street ____________________

City, ST: ________________

2. Your condition during and immediately after injury/onset: enter the details of your condition during and after your injury or onset in the space below.

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1. Your vehicle type	2. Your position in vehicle	3. What your vehicle doing at time of the accident?
Car Station wagon Van Pickup Truck Bus Large Truck Other ___________	Driver Front passenger Left rear Middle rear Right rear Other ___________	Stopped at intersection / in traffic / at light Making turn Rt / Lt Parked Proceeding along Slowing Down Accelerating Other ___________

4. Time / Speed / Damage	5. Details of Accident	6. Road Conditions
Time of accident: ________ Your vehicle speed ________mph Other vehicle speed ________mph Damage to your vehicle Mild Moderate Totaled	Visibility at time of accident Poor Fair Good Who hit who/what You hit other vehicle Other vehicle hit you You hit (Object): ________	Road conditions at the time of accident Icy Wet Sandy Dark Clear and dry Other ___________ Point of Impact Head-on left front right front Rear-end left rear right rear

7. Body Position, etc

Did you see the accident coming? Yes No Where you braced for impact? Yes No Did you have a seat belt on? Yes No Did you have a shoulder harness on? Yes No	Does your vehicle have headrests? Yes No What was the position of your headrests at time of impact? Even with top of head Even with bottom of head Middle of neck What was the direction of your head at time of impact? Facing forward Turned to the right Turned to the left

Did driver airbags deploy?   Yes   No   Did passenger airbags deploy?   Yes   No   Did side airbags deploy?   Yes   No

8. During the Accident	9. After the accident:
Did your body strike anything inside your vehicle? Yes No If yes, describe: ___________ Did you loose consciousness? Yes No If yes, how long? ___________ Your vehicle's estimated damage? ___________ Damage to their vehicle: Mild Moderate Totaled Did the police show up at the scene? Yes No Was an accident report filled out? Yes No	Check off your symptoms right after and a few days following: Headache Neck pain Stiffness Loss of smell Dizziness Mid back pain Tension Loss of taste Nausea Low back pain Nervousness Ringing in ears Fainting Chest pain Depression Diarrhea Confusion Cold hands Irritability Constipation Numbness Cold feet Chest pain Fatigue Pain behind eyes Shortness of breath Sleeping problems Other: ___________

10. Emergency room?	11. Treatment history
Where did you go after the accident? Name of Hospital - ________ Home Work Hospital ER Private Doctor How did you get there? Drove self Somebody else Ambulance Police Were x-rays done? Yes No Lab work done? Yes No Body part(s) x-rayed: ___________ What lab work: ___________ Treatments: Cervical collar Ice other: ________ Medications? ___________ Follow-up instructions: ___________ ___________	Fill in any other doctor(s) seen prior to your first visit to this office 1. Dr. ___________ First visit date: ____/____/____ Specialty: ___________ X-rays done? Yes No Types of treatment received: ___________ How many treatments? ________ Currently treating? Yes No Did Treatments benefit you? Yes No Last visit: ________/____/____ 2. Dr. ___________ First visit date: _/____/____ Specialty: ___________ X-rays done? Yes No Types of treatment received: ___________ How many treatments? ________ Currently treating? Yes No Did Treatments benefit you? Yes No Last visit: ____/____/____

12. Additional accident information

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

Current Symptom #1 (check off the boxes below to describe your first symptom. **Describe only 1 symptom per section**)

1. Check only one body location below

Headache	L	R	B
Front of head			
Top of head			
Back of head			
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other: ______________________

2. Types of pain

Dull	Sharp	Cutting	Aching	Throbbing	Burning
Numbness	Tingling	Cramping	Spasm	Stinging	Shooting
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			
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 Left			
Bending Right			
Twisting Left			
Twisting Right			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Cleaning			
Other ________			

Current Symptom #2 (**please describe only 1 symptom per section**)

1. Check only one body location below

Headache	L	R	B
Front of head			
Top of head			
Back of head			
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other: ______________________

2. Types of pain

Dull	Sharp	Cutting	Aching	Throbbing	Burning
Numbness	Tingling	Cramping	Spasm	Stinging	Shooting
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			
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 Left			
Bending Right			
Twisting Left			
Twisting Right			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Cleaning			
Other ________			

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Current Symptom #3   (**please describe only 1 symptom per section**)

1. Check only one body location below

Headache L R B
Front of head
Top of head
Back of head

Location			
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other: ____________________

2. Types of pain

Dull	Sharp	Cutting	Aching	Throbbing	Burning
Numbness	Tingling	Cramping	Spasm	Stinging	Shooting
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			
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 Left			
Bending Right			
Twisting Left			
Twisting Right			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Cleaning			
Other _________			

Current Symptom #4   (**please describe only 1 symptom per section**)

1. Check only one body location below

Headache L R B
Front of head
Top of head
Back of head

Location			
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other: ____________________

2. Types of pain

Dull	Sharp	Cutting	Aching	Throbbing	Burning
Numbness	Tingling	Cramping	Spasm	Stinging	Shooting
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			
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 Left			
Bending Right			
Twisting Left			
Twisting Right			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Cleaning			
Other _________			

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Current Symptom #5 (**please describe only 1 symptom per section**)

1. Check only one body location below

Headache	L	R	B
Front of head			
Top of head			
Back of head			
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other: ____________________

2. Types of pain

Dull	Sharp	Cutting	Aching	Throbbing	Burning
Numbness	Tingling	Cramping	Spasm	Stinging	Shooting
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			
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 Left			
Bending Right			
Twisting Left			
Twisting Right			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Cleaning			
Other ________			

Current Symptom #6 (**please describe only 1 symptom per section**)

1. Check only one body location below

Headache	L	R	B
Front of head			
Top of head			
Back of head			
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other: ____________________

2. Types of pain

Dull	Sharp	Cutting	Aching	Throbbing	Burning
Numbness	Tingling	Cramping	Spasm	Stinging	Shooting
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			
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 Left			
Bending Right			
Twisting Left			
Twisting Right			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Cleaning			
Other ________			

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Current Symptom #7   (**please describe only 1 symptom per section**)

1. Check only one body location below

Headache	L	R	B
Front of head			
Top of head			
Back of head			
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other: ____________

2. Types of pain

Dull	Sharp	Cutting	Aching	Throbbing	Burning
Numbness	Tingling	Cramping	Spasm	Stinging	Shooting
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			
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 Left			
Bending Right			
Twisting Left			
Twisting Right			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Cleaning			
Other ________			

Current Symptom #8   (**please describe only 1 symptom per section**)

1. Check only one body location below

Headache	L	R	B
Front of head			
Top of head			
Back of head			
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other: ____________

2. Types of pain

Dull	Sharp	Cutting	Aching	Throbbing	Burning
Numbness	Tingling	Cramping	Spasm	Stinging	Shooting
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			
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 Left			
Bending Right			
Twisting Left			
Twisting Right			
Coughing			
Sneezing			
Straining			
Standing			
Sitting			
Lifting			
Cleaning			
Other ________			