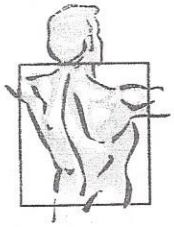

BACK & NECK CARE CENTER
OF FORT PIERCE
A specialized approach to back & neck pain relief

AUTOMOBILE ACCIDENT HISTORY

NAME:_____ TODAY'S DATE:_____

ADDRESS:_____ CITY:_____ STATE:____ ZIP:_____

AGE:_____ DATE OF BIRTH:_____/_____/_____ SEX:_____

MARITAL STATUS:_____ SPOUSE'S NAME:_____

EMPLOYER NAME AND ADDRESS:_____

OCCUPATION:_____ SOCIAL SECURITY NUMBER:_____-_____-_____

NO. OF CHILDREN AND AGES:_____

HOME PHONE: ( )_____ BUSINESS PHONE: ( )_____

Cell phone: ( )_____

INSURANCE AND ATTORNEY INFORMATION

NAME OF YOUR AUTOMOBILE INSURANCE CARRIER:_____

YOUR POLICY NO.:_____

DO YOU HAVE HEALTH INSURANCE: YES_____ NO_____

NAME OF COMPANY:_____ POLICY NO.:_____

DOES ANYONE ELSE IN YOUR HOUSEHOLD OWN AN AUTOMOBILE?:_____

WHO?_____ RELATIONSHIP TO YOU:_____

NAME OF THEIR INSURANCE COMPANY:_____

HISTORY - AUTOMOBILE ACCIDENT

DATE OF ACCIDENT: _____/_____/_____ TIME OF DAY: _____A.M. _____P.M.

LOCATION:_____

WERE YOU THE: _____DRIVER _____PASSENGER _____PEDESTRIAN _____OTHER

WHERE WERE YOU SEATED?: _____FRONT SEAT LEFT _____FRONT SEAT RIGHT

_____BACK SEAT LEFT _____BACK SEAT RIGHT _____BACK SEAT CENTER

IF YOU WERE NOT THE DRIVER, WHO WAS THE DRIVER?_____

WHO ELSE WAS IN THE CAR? _____

WHAT WAS (IS) THE MAKE & MODEL OF YOUR VEHICLE?_____

AUTOMOBILE ACCIDENT HISTORY - PAGE TWO

THE ROAD WAS _____DAMP _____WET _____DRY AT THE TIME OF THE ACCIDENT
DESCRIPTION OF ACCIDENT (INDICATE WHETHER YOUR VEHICLE WAS STOPPED OR MOVING AND WHAT CAUSED THE ACCIDENT)_____

_____

_____

_____

_____

IF YOUR VEHICLE WAS STOPPED AND STRUCK IN THE REAR, WAS IT PUSHED FORWARD?
_____YES _____NO. IF YES, HOW FAR? _____FEET.

AFTER THE FIRST IMPACT, DID YOUR CAR HAVE A SECOND (OR MORE) IMPACT WITH OTHER VEHICLE(S) OR OBJECT(S)? _____YES _____NO
IF YES, WITH WHAT?_____

YEAR(S), MAKE(S), MODEL(S) OF THE OTHER VEHICLE(S) INVOLVED IN THE ACCIDENT?

_____

WERE YOU WEARING YOUR SEATBELT: _____YES _____NO
WAS YOUR SEATBELT: _____LAP BELT ONLY _____SHOULDER HARNESS AND LAP BELT

WHAT DIRECTION WAS YOUR HEAD FACING AT THE TIME THE ACCIDENT OCCURRED?
_____FORWARD _____LEFT _____RIGHT

IF YOU WERE THE DRIVER, DID YOU HAVE YOUR FOOT ON THE BRAKES WHEN THE ACCIDENT OCCURRED? _____YES _____NO

_____ONE HAND _____BOTH HANDS WERE ON THE STEERING WHEEL (DRIVER ONLY)

WERE YOU WEARING GLASSES?_____YES _____NO

HOW DID YOU KNOW THAT THIS ACCIDENT WAS ABOUT TO HAPPEN?_____

_____

DID YOU STRIKE ANY OBJECTS INSIDE THE CAR? _____YES _____NO

WHICH OBJECTS DID YOU STRIKE?	WITH WHAT PART OF YOUR BODY?
_____STEERING WHEEL.....	_____
_____DASHBOARD.....	_____
_____WINDSHIELD.....	_____
_____HEADREST.....	_____
_____DOOR FRAME/WINDOW.....	_____
_____REAR VIEW MIRROR.....	_____
_____AIRBAG RELEASE.....	_____
_____OTHER.....	_____

CHECK ANY OF THE FOLLOWING WHICH OCCURRED:
_____SEAT BROKE _____SEATBELT BROKE _____JARRED OR THROWN ABOUT
_____CAN'T REMEMBER DETAILS

WERE YOU RENDERED UNCONSCIOUS? _____YES _____NO
IF YOU WERE UNCONSCIOUS, PLEASE EXPLAIN HOW LONG?_____

AUTOMOBILE ACCIDENT HISTORY - PAGE THREE

IF CUT, PLEASE EXPLAIN WHERE:_____
IF BRUISED, PLEASE EXPLAIN WHERE:_____

HOW DID YOU GET OUT OF THE CAR?_____

ESTIMATED DAMAGE TO YOUR VEHICLE: $_____

DID YOUR PAIN BEGIN: _____AT THE ACCIDENT SCENE _____AN HOUR LATER
_____LATER SAME DAY _____NEXT DAY _____SEVERAL DAYS OR WEEKS LATER
IF YOU HAD PAIN, NUMBNESS, STIFFNESS, ETC. PLEASE INDICATE WHERE:
_____HEAD.....FRONT _____BACK _____RIGHT _____LEFT
_____NECK.....FRONT _____BACK _____RIGHT _____LEFT
_____MID BACK..... _____RIGHT _____LEFT
_____LOW BACK.....RIGHT _____LEFT
_____EXTREMITY (___ARM ___LEG).....RIGHT _____LEFT
_____OTHER _____
LIST ANY SYMPTOMS YOU HAD OTHER THAN PAIN:_____
_____

DID THE POLICE COME TO THE ACCIDENT SCENE? _____YES _____NO
DID AN AMBULANCE COME TO THE ACCIDENT SCENE? _____YES _____NO WERE YOU TAKEN BY AMBULANCE TO THE HOSPITAL? _____YES _____NO

AFTER THE ACCIDENT, DID YOU: _____GO HOME _____GO TO WORK _____GO ABOUT YOUR BUSINESS _____GO TO HOSPITAL _____GO HOME AND LATER BE TAKEN OR DROVE TO THE HOSPITAL _____TO TO DOCTOR ____MISS ANY EVENTS OVER THE NEXT 2-3 DAYS

ON A SCALE OF 1-10, PLACE AN X AT YOUR **INITIAL DISCOMFORT** LEVEL (WHEN YOUR DISCOMFORT WAS AT ITS WORST AFTER THE ACCIDENT):

NORMAL	LOW DISCOMFORT	MODERATE DISCOMFORT	INTENSE DISCOMFORT	EMERGENCY
( )0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

HOSPITALIZATION (IF YOU DID NOT GO TO HOSPITAL, SKIP TO DR. VISIT SECTION)
WHAT WAS THE DATE OF YOUR FIRST HOSPITAL VISIT? _____/_____/_____
HOW DID YOU GET THERE: _____AMBULANCE _____DROVE MYSELF _____
DRIVEN BY _____A FRIEND _____RELATIVE

NAME OF HOSPITAL: _____LAWNWOOD _____PORT ST LUCIE _____MARTIN MEMORIAL
_____INDIAN RIVER MEMORIAL
_____OTHER (PLEASE NAME)_____

WERE YOU SEEN IN THE EMERGENCY ROOM: _____YES _____NO
WERE YOU ADMITTED TO THE HOSPITAL? _____YES _____NO

IN THE EMERGENCY ROOM OR HOSPITAL, WHAT WAS DONE?
_____EXAMINATION _____STITCHES _____ X-RAYS _____CERVICAL COLLAR
_____GIVEN HOME TREATMENT INSTRUCTIONS _____PRESCRIPTION (MEDICATION)
_____OTHER_____

AFTER YOU WERE RELEASED FROM THE HOSPITAL, WHAT DID YOU DO?
_____RETURN HOME TO BED _____RETURN TO WORK
_____RETURN TO EMERGENCY ROOM - DATE ____/____/____
_____OTHER _____

AUTOMOBILE ACCIDENT HISTORY - PAGE FOUR

DOCTOR VISITS (IF YOU HAD NO DOCTOR VISITS, SKIP TO PAST HISTORY)

WHEN DID YOU FIRST CONSULT (VISIT) A PHYSICIAN OUTSIDE THE HOSPITAL?
_____SAME DAY _____FOLLOWING DAY _____WITH A FEW DAYS
_____OTHER _____

WHO DID YOU FIRST CONSULT? DR._____
_____FAMILY PHYSICIAN _____CHIROPRACTOR _____ORTHOPEDIST _____NEUROLOGIST
_____OSTEOPATH _____OTHER_____

WHAT DID THE DOCTOR DO?
_____EXAMINATION _____X-RAYS _____PRESCRIPTION(S)
_____CHIROPRACTIC ADJUSTMENT _____PHYSICAL THERAPY
(ULTRASOUND, ELECTRICAL MUSCLE STIMULATION, ETC.)

_____OTHER _____

DID YOUR DOCTOR(S) PROVIDE ANY OF THE FOLLOWING FOR USE AT HOME?
_____CERVICAL (NECK) COLLAR _____CERVICAL PILLOW _____RIB SUPPORT
_____ARM SLING _____WRIST SUPPORT _____LOW BACK SUPPORT
_____LUMBAR PILLOW _____KNEE BRACE _____TRACTION EQUIPMENT
_____OINTMENT _____MEDICATION _____VITAMINS _____HEATING PAD
_____ICE PACK _____TENS UNIT _____OTHER _____

PROVIDE THE NAME(S), WITH DATES, TREATMENT, AND/OR TESTS PROVIDED BY ANY OTHER DOCTORS YOU HAVE SEEN SINCE YOUR ACCIDENT:

DOCTOR NAME(S)	SPECIALTY	DATES	EXAMS, TESTS, TREATMENTS

PAST HISTORY

HAVE YOU EVER HAD ANY OTHER TYPE OF INJURY? _____YES _____NO PLEASE GIVE DETAILS:_____

HAVE YOU HAD ANY SPORTS INJURIES? _____YES _____NO PLEASE GIVE DETAILS:

HAVE YOU EVER HAD ANY FRACTURES (BROKEN BONES)? _____YES _____NO
PLEASE GIVE DETAILS:_____

HAVE YOU EVER HAD ANY INJURIES WHILE IN THE MILITARY? _____YES _____NO
PLEASE GIVE DETAILS:_____

AUTOMOBILE ACCIDENT HISTORY - PAGE FIVE

IF YOU HAD A PRIOR INJURY, WERE YOU DISABLED? _____YES _____NO
ARE YOU CURRENTLY DISABLED? _____YES _____NO PLEASE GIVE DETAILS:_____

_____

HAVE YOU EVER HAD AN INJURY TO YOUR **HEAD, NECK OR BACK** OR HAVE YOU EVER BEEN TREATED FOR **HEADACHE, NECK OR BACK PAIN** BY ANY OTHER PHYSICIAN(S) PRIOR TO THIS ACCIDENT? _____YES _____NO
PLEASE EXPLAIN:_____

_____

HAVE YOU EVER HAD ANY PREVIOUS **SURGERY** OR **HEALTH CONDITION**? _____YES _____NO
PLEASE EXPLAIN:_____

_____

DO YOU HAVE ANY PRESENT HEALTH CONDITION NOT MENTIONED ABOVE? _____YES _____NO
IF YES, WHAT?_____

DO YOU TAKE OVER THE COUNTER OR PRESCRIPTION MEDICATION NOW? _____YES _____NO
IF YES, PLEASE LIST THE MEDICATIONS, THE REASON YOU ARE TAKING THEM, AND HOW OFTEN YOU TAKE THEM:_____

HAVE YOU HAD ANY **ACCIDENTS** OR **INJURIES** OF ANY KIND **AFTER** THE DATE OF THE AUTO ACCIDENT YOU ARE BEING SEEN FOR IN THIS OFFICE? _____YES _____NO
IF YES, PLEASE GIVE DETAILS:_____

_____

OCCUPATIONAL HISTORY

WERE YOU EMPLOYED WHEN YOUR ACCIDENT OCCURRED? _____YES _____NO
WHO WAS YOUR EMPLOYER?_____
WHO IS YOUR CURRENT EMPLOYER?_____

DO YOU WORK: _____PART TIME _____FULL TIME

HAVE YOU LOST ANY TIME FROM WORK SINCE THE ACCIDENT? _____YES _____NO
HOW MANY DAYS?_____ ARE YOU STILL OFF WORK? _____YES _____NO
WHAT DATE DID YOU RETURN TO WORK? _____/_____/_____

JOB DESCRIPTION: BEFORE THE ACCIDENT, WHAT WERE YOU REQUIRED TO DO AT WORK EVERY DAY?_____

_____

AFTER YOUR ACCIDENT, WHAT ARE YOU REQUIRED TO DO AT WORK EVERY DAY?_____

_____

DOES ANYTHING YOU DO AT WORK MAKE YOUR CONDITION WORSE? _____YES _____NO
IF YES, PLEASE EXPLAIN WHAT JOB DUTIES HURT YOU AND WHERE YOU HURT:_____

_____

_____

PRESENT COMPLAINTS

WHAT ARE ALL OF YOUR PRESENT COMPLAINTS (SYMPTOMS) RESULTING FROM THIS ACCIDENT? UNDER SYMPTOMS, LIST THE NAME OF THE BODY PART (ARM, LOW BACK, ETC.) WHERE YOU HAVE YOUR SYMPTOMS (PAIN, NUMBNESS, STIFFNESS, ETC.) **START WITH THE MOST SEVERE** SYMPTOMS AND FINISH WITH THE LEAST SEVERE SYMPTOMS.

SYMPTOMS	CONSTANT	COMES & GOES	WHAT MAKES YOUR SYMPTOMS WORSE	WHAT RELIEVES YOUR SYMPTOMS

ADDITIONAL COMMENTS WHICH YOU FEEL MAY BE HELPFUL TO EVALUATE YOUR CASE:

_____

_____

LEGAL REPRESENTATION

ARE YOU REPRESENTED BY AN ATTORNEY FOR THIS ACCIDENT? _____YES _____NO

NAME AND PHONE NUMBER OF ATTORNEY:_____

PATIENT'S SIGNATURE _____

PATIENT QUESTIONNAIRE REVIEWED WITH PATIENT BY:_____

Timothy J.
O'GRADY
CHIROPRACTIC
PHYSICIAN

A specialized approach to back & neck pain relief

GENERAL HEALTH HISTORY QUESTIONNAIRE

Name_____ **Date**_____
first middle last

Have you had any of the following illnesses? (Check those that apply.)

Arthritis _____	**Diabetes** _____	**Migraine Headaches** _____
Stroke _____	**Tuberculosis** _____	**Tumor/Cancer** _____
Hepatitis _____	**Rheumatism** _____	**Heart Disease** _____
Hypertension _____	**Hypoglycemia**_____	**Rheumatic Fever** _____

Have you had any surgeries performed in the past? If so, what types?_____

_____

Please list any medications you are taking_____

_____

Name/address/phone number of your family physician?_____

_____

Name/address/phone number of your family chiropractor?_____

_____

Do you have an e-mail address? If so, please provide:_____

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