WellnessOne Personal Injury History

General information:

Patient' name: _____
Today's date: _____
Date of injury: _____
Marital status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day _____ Years _____
Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy
Employment:
At time of crash: _____
☐ Unemployed
Currently: _____
☐ Unemplyed
Due to crash? ☐ Yes ☐ No
Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Past medical history:

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals): _____

Workers' comp. injuries (date, treatment, awards, residuals): _____

Personal Injuries (date, treatment, awards, residuals)

Sports or other injuries to head, neck, or back:

Past medical history (cont'd)

Any prior HISTORY of current complaints:
1. _____
2. _____
3. _____
Prior treatment by a Chiropractor for these:
1. _____
2. _____
3. _____

Current Medical history:

Current health problems: ☐ None

Current medications taken: ☐ None

Injury history:

Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other _____
Vehicle driven by: _____
Your vehicle (year, make, model): _____
Your estimated speed at moment of crash: _____
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model): _____
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know
Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean Other _____
Head position: ☐ Forward ☐ Left ___° ☐ Right ___° ☐ Up ___° ☐ Down ___°

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Injury history: (cont'd)

Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A
Brakes applied? ☐ Yes ☐ No
Crash description: _____

Crash diagram:

Aware of impending crash? ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Y ☐ N
If yes, describe _____
Did vehicle strike any objects after crash?
If yes, describe _____
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long? _____
Estimated property damage to your vehicle:
$ _____
Estimated damage to other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major
Were the police on-scene? ☐ Yes ☐ No
If yes, was a report made? ☐ Yes ☐ No

After the crash:

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck pain ☐ Paresthesia(s)
If yes, where? _____
☐ Extremity pain. If yes, where? _____
☐ Back pain
When did symptoms first appear? ☐ Immediately
(describe which symptom) _____ hr afterward
Where did you go after crash? ☐ Home ☐ Work ☐ Hospital:
Mode of transportation _____
Pvt. doctor: _____

Emergency department:

Radiographs: ☐ Yes ☐ No
Body parts imaged _____
Results _____
Lab work ☐ Yes ☐ No _____
☐ Cervical collar ☐ Ice
Medications: _____
Other: _____
Follow-up instructions: ☐ None _____

Treatment history:

1. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____
Treatment frequency: _____ Duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Treatment help? ☐ Yes ☐ No
Notes: _____

2. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____
Treatment frequency: _____ Duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Treatment help? ☐ Yes ☐ No
Notes: _____

Treatment history: (cont'd)

3. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____
Treatment frequency: _____ Duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Treatment help? ☐ Yes ☐ No
Notes: _____

4. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____
Treatment frequency: _____ Duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Treatment help? ☐ Yes ☐ No
Notes: _____

5. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____
Treatment frequency: _____ Duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Treatment help? ☐ Yes ☐ No
Notes: _____

6. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____
Treatment frequency: _____ Duration: _____
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: _____
Special tests: _____
Referred to: _____
Treatment help? ☐ Yes ☐ No
Notes: _____

Original chief complaints (if injury was not recent):

1. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

2. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

3. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

4. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

5. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

Current chief complaints:

1. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

2. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

3. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

4. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

5. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-10): _____
Temporal: _____

Self assessment as of today: % improved (list for separate areas)

_____
_____
_____

Request records:

☐ 1. Request radiographs from: _____
_____

☐ 2. Request records from: _____
_____

☐ 3. Request copy of police report.

Referral:

☐ For: _____
☐ To: _____

Tests to order:

☐ Radiographs: _____
☐ Tomograms: _____
☐ CT: _____
Area(s): _____
☐ MRI: _____
Area(s): _____
☐ MRA: _____
Area(s): _____
☐ Scintigraphy/SPECT: _____
Area(s): _____
☐ Videofluoroscopy: _____
Area(s): _____
☐ EMG/NCV: _____
Root level/nerve(s): _____
☐ SEP: _____
Root level/nerve(s): _____
☐ Other electrodiagnostic test(s): _____
☐ Ultrasound: _____
Area(s): _____

Action taken on this visit:

☐ Exam/TX: _____
_____
☐ Place on disability: _____
☐ Work restriction: _____
☐ Referral: _____
☐ Brace/collar: _____
☐ Home traction device: _____
☐ PT: _____
☐ Supplements: _____
☐ Other: _____