revive
HEALTH CENTER & SPA

AUTOMOBILE ACCIDENT HISTORY

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Last ______________________________ **First** _______________________ **Middle Initial** ______ **Birth Date** _____________**Age** _____

Address ____ **City** ________________________ **ST**________ **Zip** __________________

Phone (H) ______________________________ **(W)** __________________________________ **(C)** _______________________________

Email ____**May we send you our online newsletter?** ☐yes ☐no

Occupation ____ **Employer** ____

Spouse's Name _______________________ **Business/Employer** _______________________ **Spouse Phone:** ____________________

Who is your primary care physician? _____________________________________ **Address:** _____________________________________

Phone: ________________________ **Date of last physical/exam?** ________________ **With Whom?** _______________________________

Date of Accident: ____________________ **Time of Accident:** ___________ **am / pm** ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other ____

Was the accident on the job? ☐Yes ☐No **Where you in a company vehicle?** ☐Yes ☐No

Where were you seated in the vehicle? ☐Driver ☐Passenger ☐Rear-seat ☐Other ____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐Yes ☐No **Did you experience a flash of light or explosion in your head?** ☐Yes ☐No

Did the police come to the accident scene? ☐Yes ☐No **Is there a police report?** ☐Yes ☐No

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Did you go to the hospital? ☐Yes ☐No **When?** ☐Immediately ☐___hours later ☐___days later **Which hospital?** ___________________

How did you get to the hospital? ___________________________________ **How long did you stay in the hospital?** ________________

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)____

What areas were x-rayed? ____________________________________**What was their diagnosis?** __________________________________

What did they recommend for follow-up care? ____

Was any other doctor consulted after your accident? ☐Yes ☐No **If yes, please complete information below.**

Dr. ________________________________ **Specialty?**_____________________________ **Date first seen:**__________________

Type of treatment:____________________________ **Treatment frequency:**_______________ **How long did you treat?**________

Dr. ________________________________ **Specialty?**_____________________________ **Date first seen:**__________________

Type of treatment:____________________________ **Treatment frequency:**_______________ **How long did you treat?**________

Were you wearing a seatbelt? ☐Yes ☐No **If yes, did you receive any injury or bruise from the seat belt?** ☐Yes ☐No

Did your head hit the head rest during the accident? ☐Yes ☐No **If adjustable, was the position of the head rest altered?** ☐Yes ☐No

Was the seat adjustment altered by the accident? ☐Yes ☐No **Was the seat broken by the accident?** ☐Yes ☐No

Did the air-bag deploy? ☐Yes ☐No **If yes, did it strike you?** ☐Yes ☐No **If yes, where?** ____

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left **Body?** ☐Straight ☐Right ☐Left

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐Yes ☐No **If so, were they still on after the accident?** ☐Yes ☐No

YOUR CAR

List the year, make and model of the car you were in: YEAR: ___________ MAKE: ___________________ MODEL: ______________________

Was your car stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐No If no, estimate the speed of the vehicle you were in: ___________mph

If your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: ___________ MAKE: ___________________ MODEL: ______________________

Was the other car moving at the time of impact? ☐Yes ☐No If yes, what was the approximate speed of the vehicle : ___________mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

***Please describe, to the best of your knowledge, what happened during this accident*.**

____

____

____

____

____

____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: ____________________________________ **Name of their auto insurance:** ________________________

Policy #: _____________________________________ **Claim #:** ____

Auto insurance phone #: _______________________________________ **Name of insurance adjuster:** _________________________________

Driver of the other vehicle: ____ **Name of their auto insurance:** ____________________________

Policy #: _____________________________________ **Claim#:** ____

Auto insurance phone #: _______________________________________ **Name of insurance adjuster:** _________________________________

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: ____

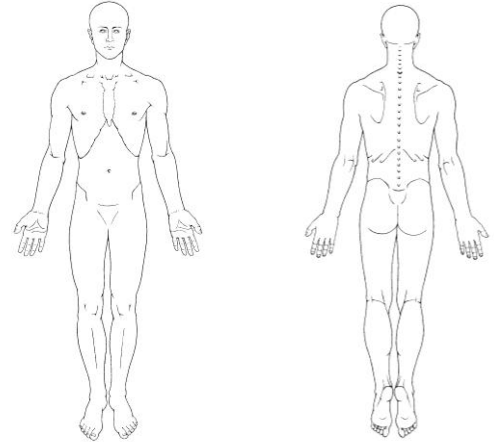
Do you still have any of those symptoms? ☐Yes ☐No **If yes, which ones?** ____

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

CURRENT COMPLAINTS -List current symptoms separately in order of severity.

Please mark areas of pain on the figures below



1* Body Part:____

Date symptom first appeared: ____________________

How often do you experience these symptoms? □Constant 100% □Frequent 75% □Intermittent 50% □Occasional 25% □Rare 10%

What makes symptom increase? ____________________________________

What makes symptom decrease?____________________________________

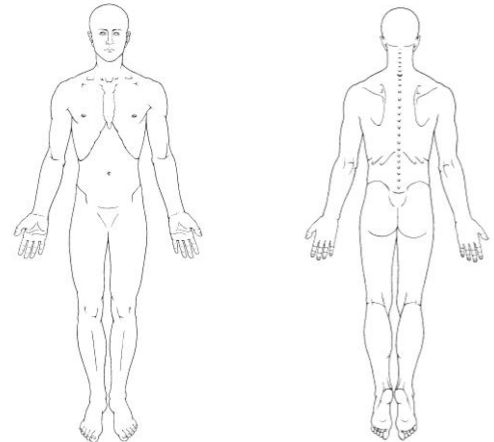
Type of pain? □Sharp □Dull □Aching □Burn □Throb □Numb □Other__________

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◊◊◊ **1** ◊◊◊ **2** ◊◊◊ **3** ◊◊◊ **4** ◊◊◊ **5** ◊◊◊ **6** ◊◊◊ **7** ◊◊◊ **8** ◊◊◊ **9** ◊◊◊ **10**

Where does pain radiate to? ____________________________________

Please mark areas of pain on the figures below



2* Body Part: ____

Date symptom first appeared: ____________________

How often do you experience these symptoms? □Constant 100% □Frequent 75% □Intermittent 50% □Occasional 25% □Rare 10%

What makes symptom increase? ____________________________________

What makes symptom decrease?____________________________________

Type of pain? □Sharp □Dull □Aching □Burn □Throb □Numb □Other__________

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◊◊◊ **1** ◊◊◊ **2** ◊◊◊ **3** ◊◊◊ **4** ◊◊◊ **5** ◊◊◊ **6** ◊◊◊ **7** ◊◊◊ **8** ◊◊◊ **9** ◊◊◊ **10**

Where does pain radiate to? ____________________________________

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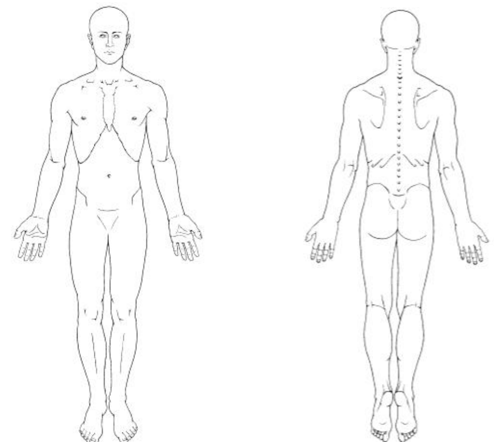

3* Body Part: ____

Date symptom first appeared: ____________________

How often do you experience these symptoms? □Constant 100% □Frequent 75% □Intermittent 50% □Occasional 25% □Rare 10%

What makes symptom increase? ____________________________________

What makes symptom decrease?____________________________________

Type of pain? □Sharp □Dull □Aching □Burn □Throb □Numb □Other__________

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◊◊◊ **1** ◊◊◊ **2** ◊◊◊ **3** ◊◊◊ **4** ◊◊◊ **5** ◊◊◊ **6** ◊◊◊ **7** ◊◊◊ **8** ◊◊◊ **9** ◊◊◊ **10**

Where does pain radiate to? ____________________________________

OCCUPATIONAL INFORMATION

Job involves: ☐Sitting ☐Standing **How long?** _______ ☐Lifting **How much?** _______ ☐Bending ☐Twisting ☐Turning ☐Stooping

Physical activity at work: ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

Have you missed any time from work due to the accident? ☐Yes ☐No **If yes, how many days?** ______ **Dates:** ____________________

Are your work activities restricted as a result of this accident? ☐Yes ☐No **If yes, please explain.**_________________________________

Do any of your work activities aggravate your present main complaints? ☐Yes ☐No **If yes, please explain.** ______________________

____

Do you smoke? ☐yes ☐no If yes, how many packs per week?______**Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _________________

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? __________________

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? ____________________________________

Do you have a high stress level? ☐yes ☐no If yes, list reasons:____

Please list any medications or vitamins you are currently taking (including dosage).

________________________________ **Frequency:**_____________ **Dosage:** _____________ **What is this for?** ____________________

________________________________ **Frequency:**_____________ **Dosage:** _____________ **What is this for?** ____________________

________________________________ **Frequency:**_____________ **Dosage:** _____________ **What is this for?** ____________________

________________________________ **Frequency:**_____________ **Dosage:** _____________ **What is this for?** ____________________

X-RAY CONFIRMATION - FEMALES

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

____ ______________________________

Patient Signature **Date**

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

____ ______________________________

Patient Signature **Date**

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at *Revive Health Center & Spa* and whomever they designate as assistants to administer care to child.

Name of Child / Minor (please print)____

Name of Parent / Guardian (please print) ____

Parent / Guardian signature: ____ **Date:** _______________________