place label here

Back Specialists
Sioux Falls, SD 57108
Auto/Work Related Accident

## About You:

Name:_____ SS#:_____/_____/_____ Date of Birth:_____/_____/_____

## Automobile Accident Related:

Date and Time of Accident:_____ ☐ a.m. ☐ p.m. Number of people in vehicle:_____
Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger
If a traffic violation was issued, to whom was it issued?_____
Did the police come to the accident site? ☐ yes ☐ no Was a police report filed? ☐ yes ☐ no
Were there any witnesses? ☐ yes ☐ no Were you wearing a seatbelt? ☐ yes ☐ no
Was this vehicle equipped with airbags? ☐ yes ☐ no If yes, did it inflate? ☐ yes ☐ no
In relation to the base of your skull, where was the headrest? ☐ above ☐ below ☐ at base of skull
What did your vehicle impact? ☐ another vehicle ☐ other-if other, explain: _____
_____
Did any part of your body strike anything in the vehicle? ☐ yes ☐ no if yes, explain:_____
_____
Make, model and year of vehicle you were occupying?_____
Name of the location/street on which you were traveling?_____
In which direction were you headed? ☐ N ☐ S ☐ E ☐ W Speed of the other vehicle?_____
In your words, please describe the accident:_____
_____
_____

## Work Related Injury:

Date and Time of Accident:_____ ☐ a.m. ☐ p.m.
Was your accident directly related to your work? ☐ yes ☐ no
Briefly describe the events that occurred just before and during your accident:_____
_____
Give the address where your work accident occurred (if other than employer's address):_____
_____
Was anyone else present during your accident? ☐ yes ☐ no Did you report it to your employer? ☐ yes ☐ no
What recommendations did your employer make just after your accident?_____
Has this type of accident happened to you before? ☐ yes ☐ no
To the best of your knowledge has this type of accident occurred in your workplace before? ☐ yes ☐ no
In general: Is your job physically stressful? ☐ yes ☐ no Is your job mentally stressful? ☐ yes ☐ no
Is your workplace noisy? ☐ yes ☐ no Have you changed jobs in the last year? ☐ yes ☐ no

## Insurance Information:

Is this case covered by insurance? ☐Group Health ☐Work Comp ☐Personal Injury ☐Disability ☐None
Insurance Company: _____ (please provide a copy of your card)
First Insured's Name:_____ (name insurance is listed under)
First Insured's Date of Birth:_____-_____-_____ First Insured's ID#:_____

## Comments:

_____

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## *After Injury:*

Did accident render you unconscious? ☐ yes ☐ no If yes, for how long?_____
Please describe how you felt immediately after the accident:_____
_____
_____
Have you gone to a Hospital or seen any other Doctor for this incident? ☐ yes ☐ no
When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus afterward
How did you get there? ☐ Ambulance ☐ Private transportation Name of Hospital:_____
Attending Doctor was a he/she: ☐ Chiropractor ☐ Medical ☐ Physical Therapist ☐ Osteopath ☐ Other
Describe any treatment you received:_____
_____Were x-rays taken? ☐ yes ☐ no
Was medication prescribed? ☐ yes ☐ no Have you been able to work since the injury? ☐ yes ☐ no
Are your work activities currently restricted as a result of this injury? ☐ yes ☐ no

✓ **Indicate the symptoms that are a result of this accident: (reading from left to right)**

| | | | |
|---|---|---|---|
| ☐ Arms/Shoulder Pain | ☐ Back Pain | ☐ Back Stiffness | ☐ Blurred Vision |
| ☐ Buzzing in Ear | ☐ Chest Pain | ☐ Difficulty Sleeping | ☐ Dizziness |
| ☐ Ears Ringing | ☐ Fatigue | ☐ Headache (s) | ☐ Irritability |
| ☐ Jaw Problems | ☐ Leg Pain | ☐ Lower Back Pain | ☐ Memory Loss |
| ☐ Nausea | ☐ Neck Pain | ☐ Neck Stiff | ☐ Numb Feet/Toes |
| ☐ Numb Hands/Fingers | ☐ Shortness of Breath | ☐ Stomach Upset | ☐ Tension |
| ☐ Other_____ | | | |

Is your condition getting worse? ☐ yes ☐ no ☐ constant ☐ comes and goes

**Indicate your degree of comfort while performing the following activities by marking accordingly:**
**C = comfortable U = uncomfortable P = painful**

| | | | |
|---|---|---|---|
| ____Bending | ____Kneeling | ____Lifting | ____Lying on Back |
| ____Lying on Side | ____Lying on Stomach | ____Pulling | ____Reaching |
| ____Running | ____Sitting | ____Sports | ____Standing |
| ____Stretching | ____Walking | ____Working | ____Other_____ |

Have you retained an attorney: ☐ yes ☐ no If yes, whom:_____Telephone:_____

## *Recovery:*

**To evaluate the effect that continuing work will have on your recovery please complete the following:**

How many hours are in your normal work day? _____
Please indicate your daily job duties and activities which you are occasionally asked to perform by ✓ the line:

| | | | |
|---|---|---|---|
| ☐ Bending | ☐ Crawling | ☐ Driving | ☐ Lifting |
| ☐ Operating Equipment | ☐ Sitting | ☐ Standing | ☐ Stooping |
| ☐ Twisting | ☐ Typing | ☐ Walking | ☐ Work with arms above head |
| ☐ Other_____ | | | |

What positions can you work in with minimal physical effort and for how long?_____
Prior to the injury were you capable of working on an equal basis with others in your age? ☐ yes ☐ no ☐ n/a
Do you work with others who can help you with any heavy lifting? ☐ yes ☐ no ☐ n/a
While in recovery, is there any light duty work you could request? ☐ yes ☐ no ☐ n/a

## *Authorization to Treat:*

- **If any of your medical or account information changes throughout the course of your care with us please be sure to notify our patient assistant immediately.**
- **Remember you are ultimately responsible for your account with *Back Specialists*, so providing us with accurate and timely information is expected.**
- **Your signature below authorizes us to treat you for the health concerns you have listed herein.**

**Patient Signature:**_____**Date**____/____/____