Florissant Medical
Quality Medical Care
(314) 921-4860

Automobile Accident
Confidential Patient Data

If you require any assistance completing this form, please ask the receptionist

Do you have or ever had any of the following conditions or diseases?
S = Self **M** = Mother **F** = Father Please check all appropriate boxes.

S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	Heart Trouble
❑	❑	❑	Alcohol/Drug Abuse	❑	❑	❑	Hepatitis
❑	❑	❑	Anemia	❑	❑	❑	High / Low Blood Pressure
❑	❑	❑	Arthritis	❑	❑	❑	HIV/ARC
❑	❑	❑	Artificial Bones/Joints	❑	❑	❑	Indigestion
❑	❑	❑	Artificial Valves	❑	❑	❑	Kidney Disorder
❑	❑	❑	Asthma	❑	❑	❑	Menstrual Cramps
❑	❑	❑	Back Pain	❑	❑	❑	Multiple Sclerosis
❑	❑	❑	Bladder Trouble	❑	❑	❑	Muscular Dystrophy
❑	❑	❑	Bone Fracture	❑	❑	❑	Neck Pain
❑	❑	❑	Bowel Control Loss	❑	❑	❑	Nervousness
❑	❑	❑	Cancer	❑	❑	❑	Numbness
❑	❑	❑	Chest Pain	❑	❑	❑	Polio
❑	❑	❑	Concussion	❑	❑	❑	Poor Circulation
❑	❑	❑	Congenital Heart Defect	❑	❑	❑	Reproductive Disorders
❑	❑	❑	Convulsions	❑	❑	❑	Rheumatic Fever
❑	❑	❑	Diabetes / Tuberculosis	❑	❑	❑	Rheumatism
❑	❑	❑	Difficulty Breathing	❑	❑	❑	Scarlet Fever
❑	❑	❑	Dislocated joints	❑	❑	❑	Serious Injury
❑	❑	❑	Epilepsy	❑	❑	❑	Severe / Frequent Headaches
❑	❑	❑	Fainting / Seizure / Epilepsy	❑	❑	❑	Shingles
❑	❑	❑	German Measles	❑	❑	❑	Sinus Trouble
❑	❑	❑	Headaches	❑	❑	❑	Venereal Disease
❑	❑	❑	Heart Surgery / Pacemaker	❑	❑	❑	Other ( )

Have you been treated by a physician for any health condition in the last 12 months? ❑Yes ❑No

Describe Condition: _____

Have you ever had a metal implant? ❑-Yes ❑-No Any metal in your body? ❑-Yes ❑-No
Are you pregnant? ❑-Yes ❑-No

If you feel pain 25% of the day, put 25%, If you feel pain half the day, put down 50%, If you feel pain all the time, put down 100%

Pain 0-10: 0-No pain, 10-very painful Main Complaint	How Intense Pain Level 0-10	How Frequent 25% - 50% 75% - 100%	Is Pain getting Worse Better Same
			Worse Better Same
			Worse Better Same
			Worse Better Same
			Worse Better Same
			Worse Better Same

Surgical History
Type of Surgery: _____ When: _____

Type of Surgery: _____ When: _____

Symptoms developed from: ❑-An auto accident on: _____

Symptoms have persisted for (indicate a number) ____-hours, _____ -days _____-Week/s _____Month/s

If your injury occurred **more than 7 days ago**, what have you done to relieve pain? (Check all that apply below)
[ ]-ice pack [ ]-heating pad [ ]-Over the counter medication [ ]-Hot baths [ ]-wore back brace

[ ]-Other: _____

Have you had these symptoms in the past 12 months? (Before this accident) ❑-Yes ❑-No
Symptoms: (Only check one) ❑-Come and go ❑-are constant ❑- are nearly constant.
Symptoms are worse in: (Only check one) ❑-morning ❑-afternoon ❑-evening

Your Occupation: _____

Please check all activities that **aggravate** your condition: (Makes you feel more pain.)

❑ Bending	❑ Lifting	❑ Standing
❑ Coughing	❑ Lying down	❑ Straining at stool
❑ Driving	❑ Reaching	❑ Turning head
❑ Getting up & down	❑ Sitting	❑ Walking
❑ Increased activity in general	❑ Sneezing	❑ Other:

Please check all activities that **relieve** your condition: (Makes you feel better)

❑ Bending	❑ Medication	❑ Stretching
❑ Heat	❑ Resting	❑ Turning head
❑ Ice	❑ Sitting	❑ Walking
❑ Lying down	❑ Standing	❑ Other:

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Please check all **additional** symptoms you may be experiencing:

❑ Blurred vision	❑ Fatigue	❑ Numbness in fingers
❑ Buzzing in ears	❑ Fever	❑ Numbness in toes
❑ Cold feet	❑ Head seems too heavy	❑ Pins and needles in arms
❑ Cold hands	❑ Headaches	❑ Pins and needles in legs
❑ Cold sweats	❑ Insomnia	❑ Ringing in ears
❑ Concentration loss / Confusion	❑ Light bothers eyes	❑ Sensitivity to cold/damp weather
❑ Constipation	❑ Loss of balance	❑ Shortness of breath
❑ Diarrhea	❑ Loss of smell	❑ Stiff neck
❑ Dizziness	❑ Loss of taste	❑ Stomach upset
❑ Face flushed	❑ Low resistance to colds	❑ Other:
❑ Fainting	❑ Muscle jerking	❑

Currently on medication? ❑-Yes ❑-No Type of Medications: _____

Your position in the vehicle:

❑-Driver ❑-Front Passenger ❑-Rear Passenger ❑-Other
❑-Middle ❑-Right ❑-Left ❑-Middle ❑-Right

The following questions **pertain to you and the vehicle you were in**:

Vehicle Size:

❑-Subcompact ❑-Compact ❑-Mid-size ❑-Heavy
❑-Full-size ❑-Mini ❑-Light ❑-Other

Vehicle Type:

❑-Car ❑-Van ❑-Station Wagon ❑-Other _____
❑-Truck ❑-Bus ❑-Pickup

Speed of Vehicle:

❑-Stopped ❑-Parked ❑-Slowing ❑-Moving at moderate speed

Why slowing or stopped:

❑-in observance of traffic signal ❑-for a pedestrian ❑-in observance of a stop sign
❑-while parking ❑-because of traffic ❑-because of a busy intersection

Collision Type:

❑-driver side impact collision ❑-passenger side impact collision ❑-front impact collision
❑-head on collision ❑-rear impact collision ❑-pedestrian incident

The Other vehicle information (**The vehicle that hit you**):

Vehicle Size:

❑-Subcompact ❑-Compact ❑-Mid-size ❑-Heavy
❑-Full-size ❑-Mini ❑-Light ❑-Other

Vehicle Type: (The vehicle that hit you)

❑-Car ❑-Van ❑-Station Wagon ❑-Other _____
❑-Truck ❑-Bus ❑-Pickup

Time of Day:
□-Full daylight □-Night □-Dusk

Road Conditions:
□-Dry □-Damp □-Wet □-Snow covered □-ice covered □-Patchy ice/snow

Visibility: □-Excellent □-Good □-Fair □-Poor
If Visibility was fair or poor, why:
□-Brightness □-Darkness □-Rain □-Snow □-Fog □-Traffic □-Other _____

The following questions are regarding the moment of impact.
Were you: □-Totally unaware that the accident was about to happen.
□-Aware that the accident was about to happen.
□-Aware that the accident was about to happen, and braced for it.

If you were the driver of the vehicle, was your **foot on the brake pedal** □-Yes□-No□-Knocked off by impact.

Wearing restraint: ❑Seat belt ❑-Shoulder harness ❑-No seat belt or harness of any kind
Air Bag: ❑Air bag deployed ❑-Air bag did not deploy ❑-No air bag, or air bag not hooked up
What position was your headrest in: ❑-High position ❑-Middle position ❑-Low position

Head
What position was your head at time of impact?
❑-Facing straight ❑-Tilted forward ❑-Rotated to the left ❑-Rotated to the right
Head was thrown:
❑-Backward and then forward ❑-Forward then backward ❑-To the left ❑-To the right
❑-To the left then the right ❑-To the right then the left

Body
What position was your body at time of impact?
❑-Straight ❑-Leaning forward ❑-Rotated to the left ❑-Rotated to the right
Body was thrown:
❑-Backward and then forward ❑-Forward then backward ❑-To the left ❑-To the right
❑-To the left then the right ❑-To the right then the left ❑-Across the vehicle ❑-Other

Damage to your Vehicle:
❑-Vehicle incurred minimal damage. ❑-Vehicle incurred moderate damage.
❑-Vehicle incurred severe damage ❑-Vehicle was totaled ❑-Damage unknown

Citation / Ticket was issued to: ❑-Driver of other vehicle ❑-Driver of the vehicle I was in
❑-Not sure if anybody received a ticket or citation.

As a result of the force of the collision, which **objects** in the vehicle did your body strike?

Head

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Backseat

Torso - Body

❑Steering wheel	❑Right door
❑Dashboard	❑Left window
❑Windshield	❑Right window
❑Armrest	❑Console
❑Headrest	❑Gear shift
❑Rear view mirror	❑Front seat
❑Left door	❑Backseat

As a result of the force of the collision, which **objects** in the vehicle did your body strike?

Right Arm

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Left Arm

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Right Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Left Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Immediately following the accident:

Did you loss consciousness/**black-out**? ❑-Yes ❑-No

Did you feel ❑–Dizzy ❑-Dazed ❑-Disoriented ❑-Weak ❑-Nervous ❑-Nauseated/Sick

Were you able to walk without help? ❑-Yes ❑-No

Where did you go? ❑-drove home ❑-was driven home ❑-was driven to the hospital ❑-drove to the hospital ❑-taken to the hospital via ambulance ❑-drove to work

Next day discomfort: ❑-Pain had increased ❑-Pain had decreased ❑-Pain remained the same

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

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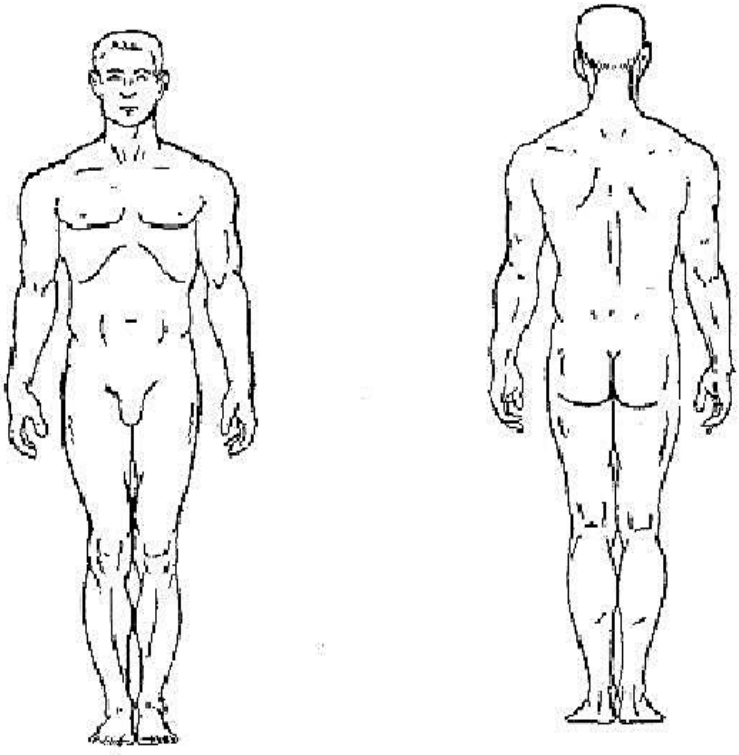
At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back	❑Pelvis					

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑ Low Back	❑Pelvis					

Please mark the location(s) of your pain using the following symbols:
S = Sharp **T** = Throbbing **A** = Aching **B** = Burning **C** = Cramps
W = Swelling **D** = Dull **N** = Numbness **F** = Stiffness



Type of pain:

[ ]-Sharp
[ ]-Throbbing
[ ]-Aching
[ ]-Burning
[ ]-Cramps
[ ]-Swelling
[ ]-Other _____
[ ]-Dull
[ ]-Numbness
[ ]-Shooting
[ ]-Tingling
[ ]-Stiffness

How do your symptoms affect your ability to perform daily activities?
[ ]-No complaints
[ ]-Mild pain with activity
[ ]-Moderate, hinders with activity
[ ]-Limiting, prevents full activity
[ ]-Intense, preoccupied with seeking relief
[ ]-Severe, no activity possible

Have any of the following been affected?
[ ]-Sleep
[ ]-Work
[ ]-Daily routine
[ ]-Other below:
_____

☐ I did NOT have these pains before the accident.
☐ I had these pains before the accident.

Patient's Signature: _____ Date of Injury: _____

Today's Date: _____