South LA Injury & Rehab

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PATIENT INFORMATION

Name: _____ Date: _____
D.O.B:_____Gender: ☐M ☐F Age:_____Weight:_____Height:_____
Cellular Phone: _____Home Phone: _____
IN CASE OF EMERGENCY, CONTACT_____
Tel: _____Relationship:_____
***FOR WOMEN:** ARE YOU OR MIGHT BE PREGNANT ☐No ☐Yes ☐ Maybe

Date of Accident: _____Time of Accident:_____AM/PM
☐Driver ☐Passenger ☐Other_____
Describe how the accident happened in your own words:_____
_____
_____
_____
_____
_____

CHECK WHERE YOU WERE SITTING AND MARK WHERE YOUR VEHICLE WAS HIT

I was hit ☐front ☐rear-ended ☐ T-bones (driver's side) ☐ T-bones (passenger's side) ☐ Other



Make and model of vehicle you were in:
_____
Were you wearing a seatbelt? ☐No ☐Yes
Did the airbags inflate? ☐No ☐Yes

Make and model of other vehicle:
_____
Direction he/she was heading:_____
Speed he/she was traveling:_____

Site of Accident:_____
Speed you were traveling:_____
Did your vehicle impact another vehicle? ☐No ☐Yes_____
Did your vehicle impact a structure? ☐No ☐Yes_____

At the moment of the impact:
Was your foot on the brake? ☐No ☐Yes
Were you surprised by the impact? ☐No ☐Yes
Did part of your body hit anything in the vehicle? ☐No ☐Yes_____
Where were you looking? ☐Straight ahead ☐To the side ☐Other_____
Where did you have your hands? ☐Steering Wheel ☐Phone ☐Lap ☐Other_____

After the accident:
Were you unconscious? ☐No ☐Yes For how long?_____
Did the police arrive? ☐No ☐Yes; Do you have the police report? ☐No ☐Yes

Describe how you felt immediately after the accident:_____

_____

_____

Did you go to the hospital? ☐No ☐Yes When?_____

How did you get to the hospital?_____

Name of Hospital:_____

Diagnosis: _____

Treatment received: ☐Chiropractor ☐Physical Therapy ☐Home-rest ☐Other_____

_____

Were you symptom-free before the accident? ☐No. I had pain on_____☐Yes

Have you taken any pain killers? ☐No ☐Yes What? _____

Have you had a previous accident? ☐No ☐Yes When? _____

Have you stopped working due to the injuries? ☐No ☐Yes How long? _____

How often do you have pain? _____

Pain worsens when I am ☐Walking ☐Bending ☐Sitting ☐Getting up

☐Lying down ☐Pushing ☐Standing ☐_____

Pain began ☐Gradually ☐Suddenly

Pain interferes with my ☐Work ☐Daily routine ☐Sleep

Check any of the following symptoms that appeared due to the accident, and the intensity:

☐Neck pain __/10; Range of motion affected ☐No ☐Yes

☐Back pain __/10; Range of motion affected ☐No ☐Yes

☐Shoulder pain __/10; Range of motion affected ☐No ☐Yes

☐Knee pain __/10; Range of motion affected ☐No ☐Yes

☐Leg pain __/10; Range of motion affected ☐No ☐Yes

☐Arm pain __/10; Range of motion affected ☐No ☐Yes

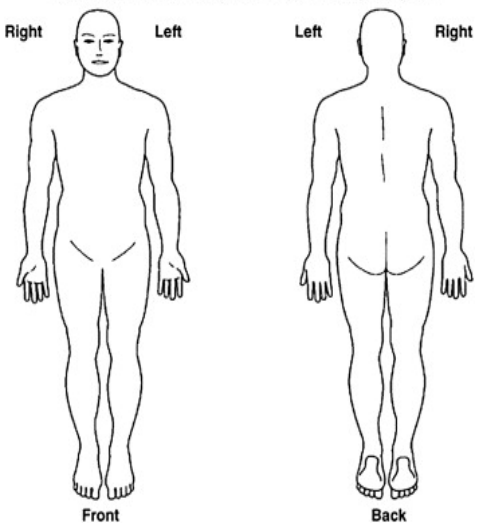
☐Chest pain ☐Headache

☐Nausea/Dizziness ☐Loose of balance

☐Loose of appetite ☐Shortness of breath

☐Vomiting

☐Other_____



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health. Also, I commit to show up to the set appointments with all my effort.

Signature: _____Date:_____

(If Patient's parent, Guardian, or Personal Representative is signing for the patient, sign, print your name and relationship to the patient.)