TOTALMD

Patient Initial Evaluation

Date: _____

Name: _____

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Date of Accident: ____/____/____ Time of Accident: _____

Road Condition: ☐ Wet ☐ Dry ☐ Raining

Describe the accident (speed, location of accident, time of accident, how did it happen?)

_____

_____

_____

_____

What city? _____ Street name: _____

Were you the driver or a passenger? ☐ Driver ☐ Passenger

Which area of the vehicle was hit? _____

Were there any immediate injuries? _____

_____

Did you feel any pain later in time (describe areas of injury) _____

_____

Did you lose consciousness? ☐ Yes ☐ No How long? _____

Did you go to the Hospital? ☐ Yes ☐ No When? _____ Ambulance? _____

If yes, what hospital? _____

List all of the doctors that you have seen for injuries sustained in this accident:

_____

_____

List all medications that you have received for injuries sustained in this accident?

_____

_____

List all tests or treatments that you have received for injuries sustained in this accident?
(i.e. X-rays, CT scans, Stitches, Casts, Manipulation, Physical Therapy, Injections)

_____

_____

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Are you right or left handed? ☐ Right ☐ Left Are you a smoker? ☐ Yes ☐ No Frequency? _____

Occupation? _____

Describe your job (What are your job duties? Do you sit or stand for long periods of time? Do you lift heavy objects or do repeated bending or stooping?)

_____

_____

_____

_____

Have you ever been injured in a motor vehicle or other accident in the past?

_____

Do you have any major medical problems? _____

_____

Do you take any medication on a regular basis? (please list) _____

_____

Have you had any surgery? _____

Are you pregnant? _____

Are you allergic to any medication? _____

Since the accident have you had problems with any of the following: (please describe)

☐ Headaches _____

☐ Sleep _____

☐ Toileting, bathing, combing hair, etc. Sitting _____

☐ Standing _____

☐ Driving _____

☐ Eating _____

☐ Lifting _____

☐ Fear or anxiety _____

How do your injuries effect your ability to work? _____

_____

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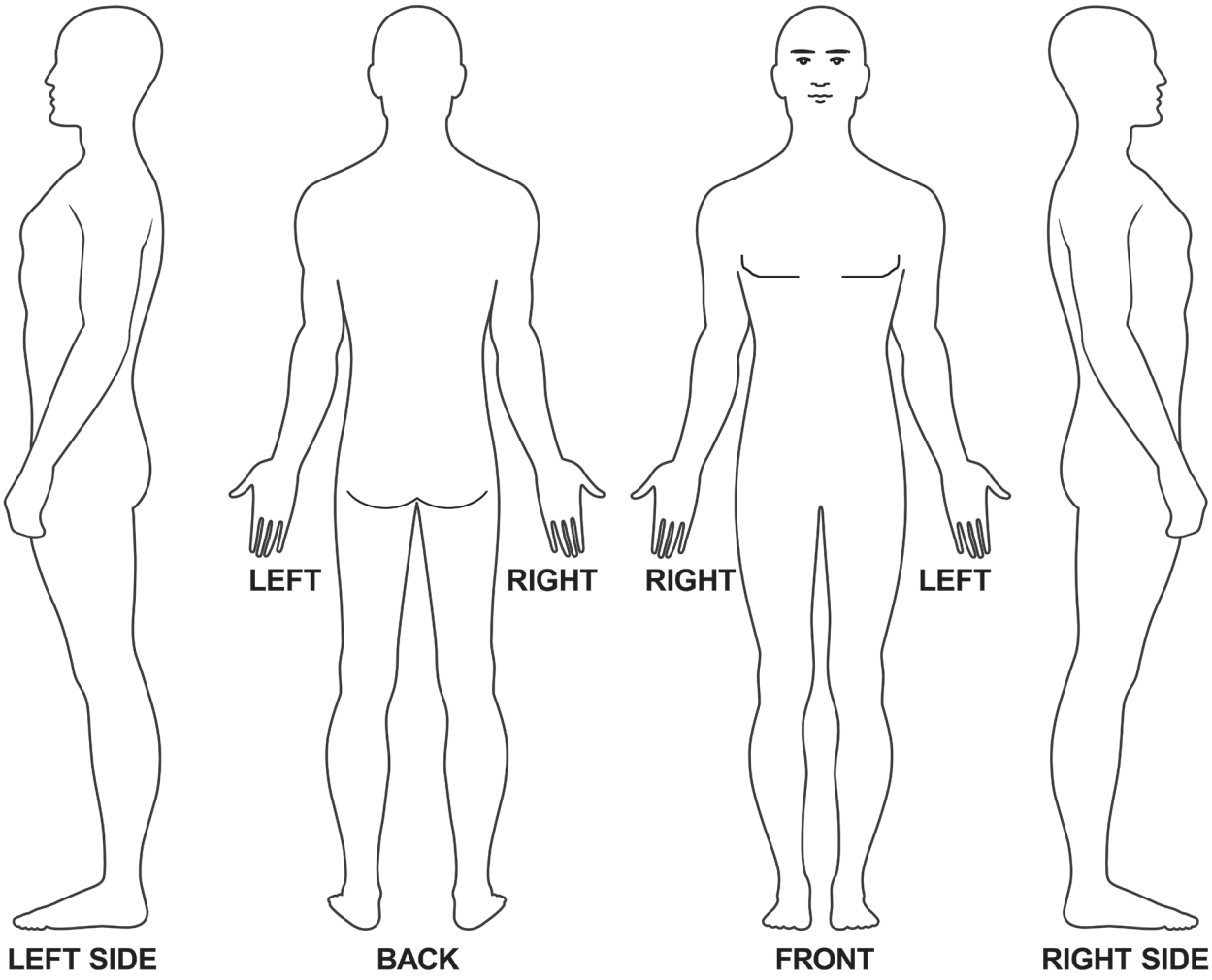
Where is your pain now?

Please mark an "X" in the area where you feel pain that was a direst result of the accident.



Patient's Name

X

Patient's Signature