

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex M F Marital Status M S D W Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

**1. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s) as a result of this accident:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Since the Motor Vehicle Collision, have you experienced any of the following:**

- A. Loss of Range of Motion: yes/no
  - a. What body part(s): \_\_\_\_\_
- B. Visual Disturbance: yes/no (please explain): \_\_\_\_\_
- C. Dizziness: yes/no How often: \_\_\_\_\_
- D. Anxiety: yes/no How often: \_\_\_\_\_
- E. Depression: yes/no How often: \_\_\_\_\_
- F. Difficulty Sleeping: yes/no How often: \_\_\_\_\_

**3. Past Health History:**

**A. Previous illnesses you've had in your life:**

\_\_\_\_\_

**B. Previous Injury or Trauma:**

\_\_\_\_\_

Have you ever broken any bones? Which?

\_\_\_\_\_

**C. Allergies:**

\_\_\_\_\_

**D. Medications:**

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____