PALMETTO PHYSICAL MEDICINE
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This questionnaire is designed to help us better understand your accident, and allow us to best treat the injuries resulting from the accident. Please read each question carefully, and answer each question as accurately as you possibly can.

This injury was due to an:

Date of Auto Accident:

Was the MVA on the job? ___Yes ___No Time of Day of MVA:

Crash Description:

Where were you sitting in the vehicle?

___Driver seat ___Passenger front ___Driver side passenger ___Passenger rear

___Motorcycle Driver ___Motorcycle Passenger ___Other:

Vehicle driven by:

Were you wearing a seatbelt? ___Yes ___No

Does your vehicle have an airbag? ___Yes ___No

Did it deploy? ___Yes ___No

If yes, were you struck? ___Yes ___No

Vehicle (Year, Make & Model):

What type was the other vehicle?

From what direction was the impact?

___Front ___Rear ___Left ___Right

What was your approximate speed at the time of impact? _____MPH

What was the approximate speed of the other vehicle? _____MPH

Were you going: ___Forward ___Stopped ___Slowing ___Accelerating
___Backward ___Turning Left ___Turning Right

Road Conditions: ___Dry ___Damp ___Wet ___Snow ___Ice Other:

Was your foot on the brake pedal? ___Yes ___No

Were you surprised by the impact? ___Yes ___No

How much damage was there to the outside of your vehicle? ___None ___Some ___Major

Immediately after the accident were you: ___Conscious ____Dazed ___Unconscious

If unconscious, for how long?

Head Restraints: ___None ___Integral Type **Adjustable Type:** ___Up ___Down ___Unknown

If Adjustable, was the position altered by the crash? ___Yes ____No

Was the seat back adjustment altered by the crash? ___Yes ___No

Was the seat broken? ___Yes ___No

Did you strike your head? ___Yes ___No

At impact, was your body straight in your seat? ___Yes ___No

If NO, turned to the: ___Left ___Right ___Forward Lean ___Other

At impact, were you looking straight ahead? ___Yes ___No

If NO, was your head turned: ___Left ___Right ___Up ___Down

Hands: ___One on Wheel ___Two on Wheel ___N/A **Brakes Applied?** ___Yes ___No

Did your shoulder hit the door? ___Yes ___No

Did your knees hit the dashboard? ___Yes ___No

How did you get out of your vehicle? ___On your own ___Helped out ___Taken out by someone

Were you wearing a hat or glasses? ___Yes ___No

If yes, still on after the incident? ___Yes ___No

Estimated property damage to your vehicle? $_____

Rate the other vehicle's damage: ___None ___Minimal ___Moderate ___Major

Was there a police report made? ___Yes ___No

Rate the impact of the accident, 1=slight bump, 10=locomotive

Impact Rating:

Did you go to the hospital? ___Yes ___No

If yes, how did you get there?

If you went to the hospital or saw another doctor, please answer the following:

Hospital Name:

Doctor Name:

Diagnosis:

Treatment Received:

Medications Given:

Tests Performed:

Other Instructions:

Were you admitted to the hospital? ___Yes ___No

If yes, how long was your stay?

Were you dismissed from the ER? ___Yes ___No

Are you experiencing any of the following since your accident?

___Headaches ___Blurry Vision ___Dizziness/Loss of Balance ___ Shoulder Pain

___Neck Pain ___Rapid Heartbeat ___Blood/Lymph Disorders ___ Elbow Pain

___Anxiety ___Urinary Difficulties ___Indigestion ___Wrist/Hand Pain

___Fatigue ___Skin Problems ___Hot/Cold Flashes ___Upper Back Pain

___Sore Throat ___Memory Lapses ___Low Back Pain ___Weight Loss/Gain

___Knee Pain ___Chest Pain ___Ankle/Foot Pain ___Breathing Problems

___Hip Pain ___Mid Back Pain ___Digestive Problems

Where did you go after the crash? ___Home ___Work ___Hospital ___Doctors Office

By EMS? ___Yes ___No

This questionnaire is designed to allow us to gain a better understanding of your PRIMARY complaint/injury. Please take the time to read each question carefully, and answer each question as accurately as you possibly can. This will allow Palmetto Physical Medicine to provide you with the best possible care.

Please check any of the following symptoms that you are currently experiencing or have experienced in the past 12 months: (SELECT ALL THAT APPLY)

___Tension Across Top of Shoulder ___Neck Pain/Stiffness ___Carpal Tunnel

___Mid back pain ___Tension/Headaches ___Shoulder Pain

___Elbow Pain ___Wrist Pain ___Hand/Finger Pain

___Neck Pain Radiating to Upper Extremities ___Weakness in Upper Extremities

___Numbness/Tingling in Arms/Hands ___Pain in the Arms ___Pain in the Hands

___Numbness/Tingling in Legs/Feet ___Pain in the Legs ___Pain in the

Feet

___Swelling/Edema in the Arms/Hands ___Swelling/Edema in the Legs/Feet

___Low back Pain Radiating to Lower Extremities ___Weakness in Lower Extremities

___Hip Pain ___Low Back pain ___Knee Pain ___Ankle Pain ___Gain Disturbances

___Fainting ___Loss of Memory ___Chest Pain ___Shortness of Breath

___Fatigue ___Sudden Weight Loss ___Depression ___Bowel/Bladder Changes

___Allergies ___Diabetes ___Difficulty Sleeping ___Fibromyalgia ___Digestive Problems

___Other (Please explain):

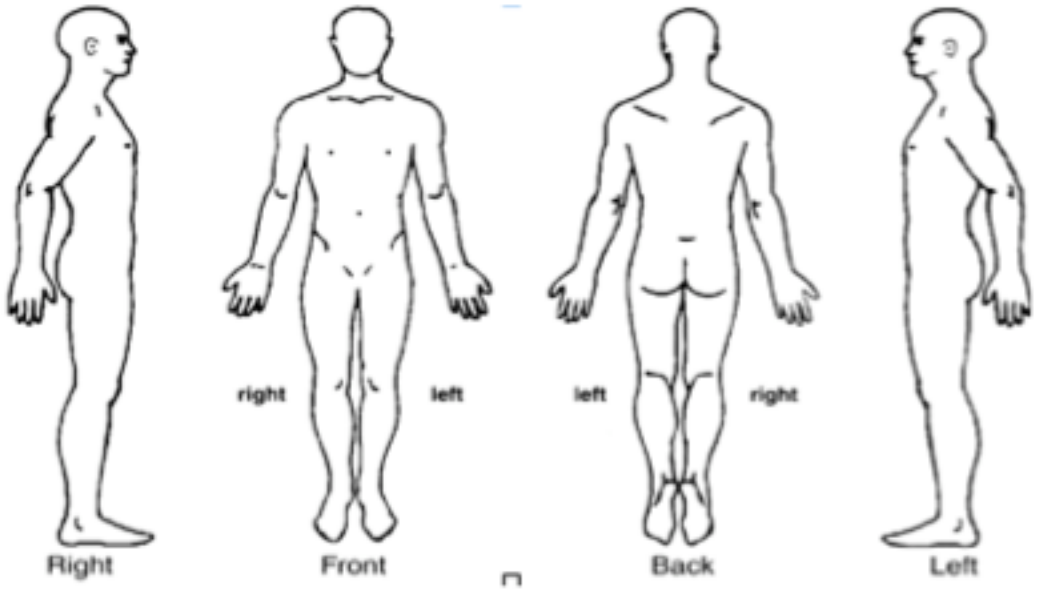
Please rank your top 3 of the above conditions.

1.

2.

3

Please mark ALL of your problem areas.



Please select a MINIMUM of 3 short term goals based on your top complaints:

___Decrease Inflammation ___Increase Strength ___ Improve/Restore Posture

___Improve Biomechanical Function ___Increase Mobility ___ Increase Daily Activities

___Increase Range of Motion ___ Improve Gait ___ Increase General Fitness

___Decrease Compensatory Patterns ___ Increase Stability ___ Restore Ligament Function

Please list a MINIMUM of 3 long term goals based on your top complaints:

1.

2.

3.

4.

Please answer all of the following questions based on the #1

complaint chosen from above.

This injury was due to an:

What were you doing when your symptoms began?

When was the first time you had this problem? When did the most recent episode begin?

How long do the episodes last?

Was the onset of symptoms: ___Sudden ___Gradual ___Chronic

What do your symptoms feel like? (SELECT ALL THAT APPLY)

___Dull ___Sharp ___Burning ___Throbbing ___Stabbing ___Electric ___Tingling ___Numbness Other:

Since the first occurrence, how many severe episodes have you had?

___5 or less ___Between 6 and 9 ___More than 10

What increases the symptoms? (Check all that apply)

___Lifting ___Bending ___Sitting ___Standing ___Seated to Standing ___Lying Down

Other:

What have you tried previously that has been unsuccessful in aiding in the FULL relief of your condition? (CHECK ALL THAT APPLY)

___Aleve/Naprosyn ___ Heat ___Motrin/Ibuprofen ___ Oral Steroids

___Muscle Relaxers ___Massage ___Tylenol/Acetaminophen ___ Bracing

___Prescription Pain Meds ___Ice ___ Steroid Injections ___ Daily Activities

___ Decompression ___ Lying Down ___ Viscosupplementation
___Excedrin

___ Other:

___Medications are contraindicated. ___ Patient refuses to take oral medications.

Do your symptoms radiate anywhere? ___No ___Yes

If yes, where EXACTLY do you feel the symptoms radiate?

What is the severity of your symptoms from 0-10, with 0 being being the worst symptom imaginable?

At its best:

At its worst:

Average Pain:

Current Pain:

How often do you feel your symptoms? ___Constant ___Daily ___Occasional

Since it started, have your symptoms gotten: ___Worse ___Better ___Stayed the same

Is it worse at a certain time of day? ___Morning ___Midday ___Night ___NO

Have you had any previous treatment for your condition? ___Yes ___No

If yes, what have you had?

Are you currently receiving Physical Therapy, Occupational Therapy, Speech Therapy or Home Health? ___Yes ___No

Have you had any previous imaging for this condition?

___None ___CT ___Scan ___MRI ___Bone Density Scan ___X-Ray

Where was it taken?

When was it taken?

What part of the body did you receive this imaging on?

Is there anything else about your #1 complaint we need to know about?

Please answer all of the following questions based on the #2 complaint chosen from above.

How long has this been bothering you?

What is the severity of your symptom, at 10 its worst, from 0-10?

What have you tried previously that has been unsuccessful in aiding in the FULL relief of your condition? (CHECK ALL THAT APPLY)

___Aleve/Naprosyn ___ Heat ___Motrin/Ibuprofen ___ Oral Steroids

___Muscle Relaxers ___Massage ___Tylenol/Acetaminophen ___ Bracing

___Prescription Pain Meds ___Ice ___ Steroid Injections ___ Daily Activities

___ Decompression ___ Lying Down ___ Viscosupplementation ___Excedrin

___ Other:

Have you had any previous treatment for your condition? ___Yes ___No

If yes, what have you had?

Have you had any previous imaging for this condition?

___None ___CT ___Scan ___MRI ___Bone Density Scan ___X-Ray

Where was it taken?

When was it taken?

What part of the body did you receive this imaging on?

Please answer all of the following questions based on the #3 complaint chosen from above.

How long has this been bothering you?

What is the severity of your symptom, at 10 its worst, from 0-10?

What have you tried previously that has been unsuccessful in aiding in the FULL relief of your condition? (CHECK ALL THAT APPLY)

___Aleve/Naprosyn ___ Heat ___Motrin/Ibuprofen ___ Oral Steroids

___Muscle Relaxers ___Massage ___Tylenol/Acetaminophen ___ Bracing

___Prescription Pain Meds ___Ice ___ Steroid Injections ___ Daily Activities

___ Decompression ___ Lying Down ___ Viscosupplementation ___Excedrin

___ Other:

Have you had any previous treatment for your condition? ___Yes ___No

If yes, what have you had?

Have you had any previous imaging for this condition?

___None ___CT ___Scan ___MRI ___Bone Density Scan ___X-Ray

Where was it taken?

When was it taken?

What part of the body did you receive this imaging on?

Do you have any of the following health care benefits? ___HSA HRA FSA 125 Plan

How did you hear about us? (Select ALL That Apply)

___Doctor:

___Family Member:

___Friend:

Please list name of referring physician or other persons

Internet:

___Groupon ___Facebook ___Living Social ___Other:

___Newspaper:

___Television:

___Radio:

___Billboard

___Other: