Accident Record of Events

Name:_____ **Today's date:**_____

Referred by:_____

Type of accident (ex:MVA/fall):_____

Date of accident:_____

Brief description of
accident:_____
_____
_____
_____

Were you the driver or passenger?:_____

If MVA, where was your vehicle was hit?:_____

(For the next 6 questions, please circle the correct response)

Did airbags deploy?: Yes No N/A

Were you wearing a seatbelt?: Yes No N/A

Did you lose consciousness?: Yes No N/A

Were you cited by the police?: Yes No N/A

What the other driver cited by the police?: Yes No N/A

Do you have a previous history of pain to the area currently affected?: Yes No N/A

If yes to above question, please describe treatments that you received in the past **that provided relief for your pain**: (examples include bed rest, physical therapy, chiropracter, home exercise, stretching, ice, heat, epidurals, joint injections, nerve blocks, rhizotomy, surgery, other):_____
_____

If yes to above question, please describe treatments that you received in the past, **that did not provide relief for your pain**: _____
_____

Please list **medications that have helped to treat your pain**? :(examples include motrin, aleve, tylenol, opiates, muscle relaxers, gabapentin, lyrica):_____
_____
_____

Please list medications, used to treat your pain, that you did not tolerate or had side effects to them:
_____

Name: _____ Date: _____

Pain History- please help us to understand your pain better

When did your pain start or worsen ? : _____

(Please circle all that apply)

Location of pain: Neck middle back lower back other: _____

Is one-side worse than the other?: Right left middle

Does the pain move anywhere?: Shoulders arms hands head buttock hips groin legs ankle feet abdomen chest

Is the pain constant, or does It come and go?: Constant comes and goes

How severe is your pain?: (0=no pain, 10=unbearable pain) _____

Severity of pain on a good day (1–10): 1–3 4–7 8–10

Severity of pain on a bad day (1–10): 1–3 4–7 8–10

What is the average severity of pain (1–10): 1–3 4–7 8–10

What is the character of the pain? (Please circle all that apply)

Aching stabbing throbbing burning electric pinching pressure spasm-like tightness soreness on fire cramping other: _____

What aggravates your pain (make sure pain worse)? (Please circle all that apply)

Standing walking bending turning twisting lifting sitting looking up looking down looking to the side lying flat lying on sides

Other: _____

What alleviates your pain (takes pain away or lessens your pain)? (Please circle all that apply)

Heat packs heating blanket ice packs massage BenGay/tiger balm stretching sitting lying down changing position back brace neck brace standing walking other: _____

Are you having muscle cramps, spasms, or charley horses? (If yes, where): Yes no _____

Are you having numbness, tingling, burning? (If yes, where): Yes no _____

Are you having any incontinence (wetting the bed, soiling the bed) and for how long? Yes no ____

What treatments have you taken for your pain and did they help?: bed rest motrin/aleve tylenol opiates muscle relaxers physical therapy chiropracter home exercise/stretching bed rest ice heat epidurals joint injections nerve blocks rhizotomy surgery other: _____

General medical symptoms

Please tell us about any other symptoms that you are having : (if you answer yes, please describe)

New weight loss or fatigue: yes no _____

New itching or rashes: yes no _____

New changes in vision: yes no _____

New breathing problems : yes no _____

New chest pain or palpitations: yes no _____

New problems eating or swallowing: yes no _____

New abdominal pain or rectal bleeding: yes no _____

New constipation: yes no _____

New bleeding or clotting problems: yes no _____

New weakness: yes no _____

New problems with balance: yes no _____

New feelings of depression, anxiety, hostility: yes no _____

New incontinence (wetting or soiling the bed or yourself): yes no _____