Patient Information Form

The following information is needed in order to better serve you. Please complete all questions.

First Name _____ Middle Name _____ Last Name _____

Nick Name _____ SSN _____

Email _____

- ○ Send me appointment confirmations
- ○ Send me office news and updates

Address _____

City _____

State _____ Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Gender ○ Male ○ Female

Birth Date _____

Occupation _____

Employer _____

Employers Address _____

Marital Status ○ Married ○ Single ○ Divorced

How did you hear about us?

○ Self-Referral ○ Screening ○ ECSC Website
○ Yelp / Google ○ Online Deal ○ Insurance Website
○ Existing Patient _____

Spouse's Name _____ Phone Number _____ Occupation _____

Spouse's Employer _____ Employer's Phone Number _____

Employer's Address _____

_____

AUTO ACCIDENT INFORMATION

Patient Name: _____ Date: _____

INSURANCE INFORMATION:
Your AUTO Ins. Co: _____ Your Claim # _____
Claim Adjuster: _____ Phone# _____
Vehicle driven by: _____

Driver of other car: _____
Other Driver's address: _____
Phone # _____
Insurance Co. _____ Policy # _____

Date of Collision: _____ Time: _____
Road Conditions: ☐ Wet ☐ Dry ☐ Damp ☐ Ice ☐ Snow ☐ Other
Description of Collision: _____
_____
_____

Driver: ____ Passenger: ____ Front Seat: ____ Rear Seat: ____
Which direction were you heading? ☐ North ☐ South ☐ East ☐ West
On (name of street): _____
Which direction was the other vehicle heading? ☐ North ☐ South ☐ East ☐ West
On (name of street): _____

Make & Model of your car: _____ Year: _____
Approximate amount of damage: _____ Drivable: ○ Yes ○ No

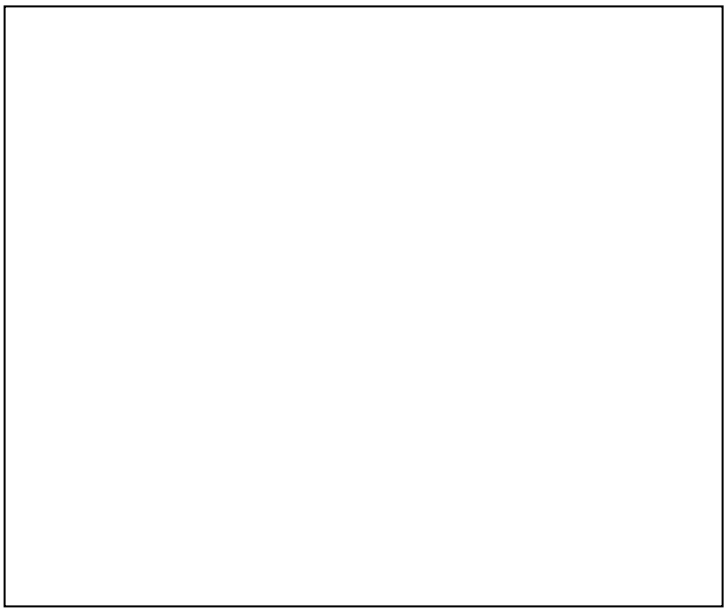
Make & Model of other car: _____ Year: _____
Approximate amount of damage: _____ Drivable: ○ Yes ○ No

Were the police notified? ○ Yes ○ No Was a police report filed? ○ Yes ○ No Number _____
Do you have an attorney? ○ Yes ○ No Name _____ Phone: _____
Have you had any other personal injuries/collisions?
○ None ○ Past Year ○ Past 5 Years ○ Over 5 Years
Describe: _____

The information I have given to Emerald City Spinal Care is complete and true to the best of my knowledge.

Signature: _____ Date: _____

Crash Diagram:



Crash Description:_____
_____
_____
_____
_____
_____
_____
_____
_____

Aware of impending crash? ○ Yes ○No
Did you tense up during the crash? ○ Yes ○No

During the crash:
Did your body strike any part of the vehicle? ○ Yes ○ No
If yes, describe _____

Did vehicle strike any objects after crash? If yes, describe
_____

Wearing hat or glasses? ○ Yes ○ No
If yes, still on after crash? ○ Yes ○ No

Did you lose consciousness? ○Yes ○ No
If yes, for how long? _____

Accident General History:
Was the crash on-the-job? ○ Yes ○ No
What was your estimated speed at the moment of crash:
_____
○ Stopped ○ Slowing ○ Accelerating

Car Seat Head Restraints: ○ None ○ Integral
○ Adjustable ○ Up ○ Down ○ Don't know
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
Lap belt: ○ Wearing ○ Not wearing ○ Don't know
Shoulder belt: ○None ○ Wearing ○ Not wearing
○ Don't know

Did air bag deploy? ○ Yes ○ No
If yes, were you struck? ○ Yes ○ No

Body position: ○ Neutral ○ Forward lean
○ Other _____
Head position: ○ Forward ○ Left ___° ○ Right ___°
○ Up___° ○ Down ___°
Hands: ○One on wheel ○Two on wheel ○N/A
Brakes applied? ○ Yes ○ No

Where did you go after crash?
○ Home ○ Work ○ Hospital □ _____
Mode of transportation _____

Symptoms after the crash:
□ Headache □ Dizziness □ Nausea
□ Confusion/disorientation □ Neck Pain
□ Paresthesia (tingling/numbness) If yes, where?
_____
□ Mid Back Pain □ Low Back Pain
□ Extremity Pain If yes, where?
_____

When did symptoms first appear?
○ Immediately
○ _____minutes/hours/days later (circle)

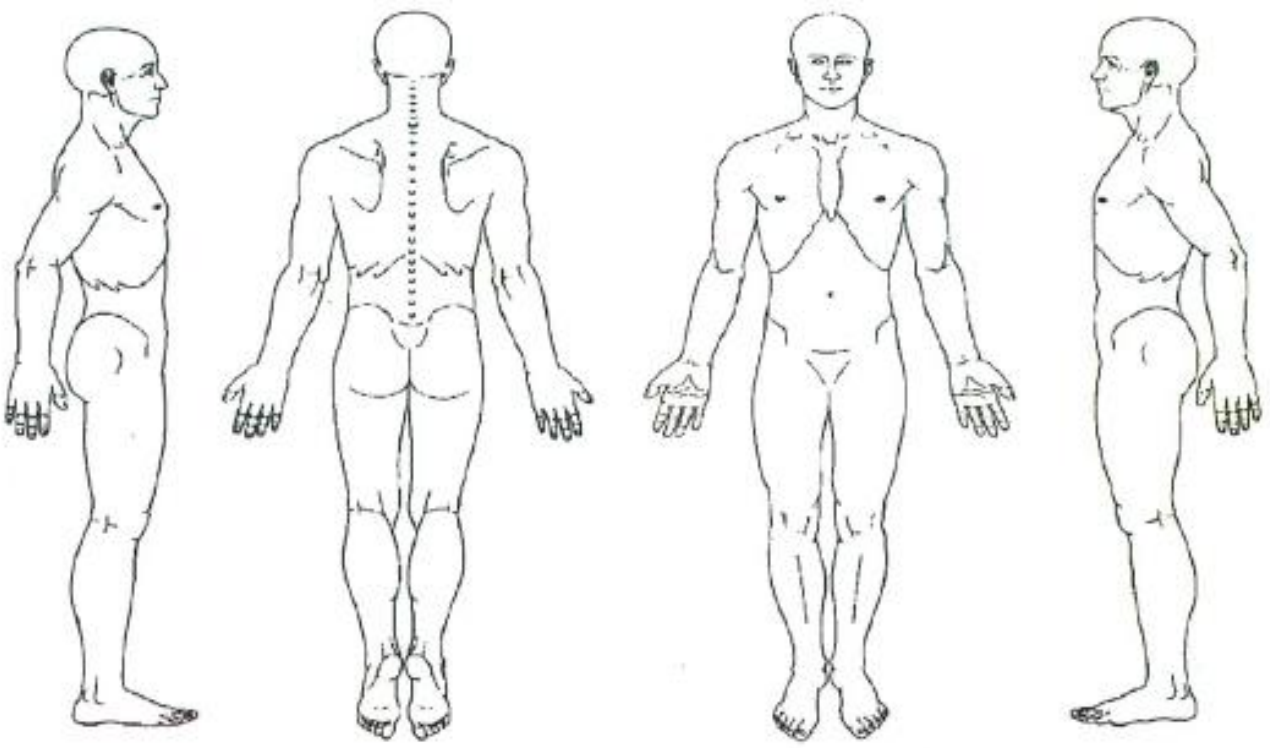
Patient Symptom Diagram

Indicate the location and type of symptoms that you are experiencing

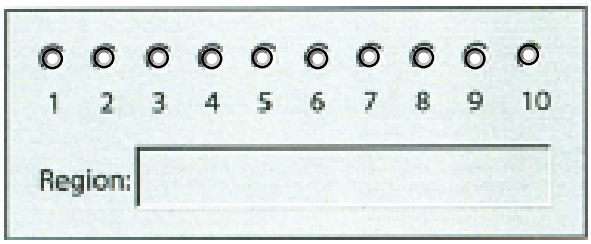
Please mark on the diagram the following

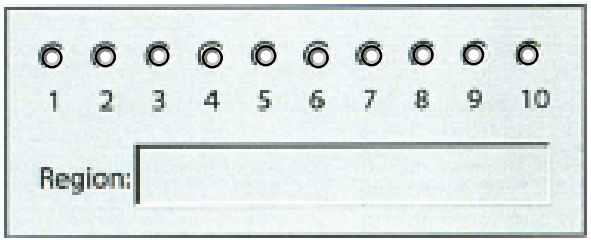
Numbness	= = = = =	Burning	x x x x x
Pins/Needles	o o o o o	Stabbing	/ / / / /
_____	^ ^ ^ ^ ^	Aching	a a a a a

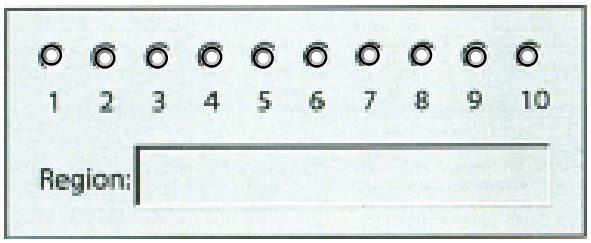
(Please describe the symptom)

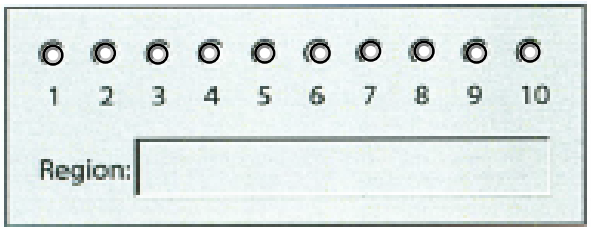


Please indicate the region of pain (ie. shoulder, legs, etc.) and its severity, with 10 being incapacitated









Please describe your main complaint: _____

_____

Please describe how and when this problem started: _____

_____

Which of the following makes the symptoms better?

- ○ Rest
- ○ Heat
- ○ Medication
- ○ Stretching
- ○ Sitting
- ○ Ice
- ○ Laying down
- ○ Walking
- ○ Standing
- ○ Movement
- ○ Other _____

Which of the following makes the symptoms worse?

- ○ Rest
- ○ Heat
- ○ Medication
- ○ Stretching
- ○ Sitting
- ○ Ice
- ○ Laying down
- ○ Walking
- ○ Standing
- ○ Movement
- ○ Other _____

Describe your pain symptoms

- ○ Sharp
- ○ Achy
- ○ Burning
- ○ Stabbing
- ○ Pin/Needles
- ○ Fatigue
- ○ Dizziness
- ○ Dull
- ○ Other: _____

How often do you experience your symptoms?

- ○ Constant (100-75%)
- ○ Frequent (74-50%)
- ○ Intermittent (49%-25%)
- ○ Occasional (24-1%)

Do the symptoms radiate anywhere?

- ○ Neck
- ○ Shoulder
- ○ Arm
- ○ Fingers
- ○ Leg
- ○ Knee
- ○ Ankle
- ○ Toes

How severe are the symptoms?

- ○ Minimal
- ○ Mild
- ○ Moderate
- ○ Severe

When do you or experience symptoms?

- ○ Morning
- ○ Afternoon
- ○ Evening
- ○ All the time
- ○ Sporadically

When was the last time you experienced this? _____

Is the condition: ○ Improving ○ Staying the same ○ Worsening

Bournemouth Questionnaire

Instructions: The following scales have been designed to find out about your pain/discomfort and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your **pain/discomfort**?

   No pain — Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain/discomfort **interfered with your daily activities** (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

   No Interference — Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain/discomfort **interfered with your ability** to take part in recreational, social, and family activities?

   No Interference — Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, **how anxious** (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at all anxious — Extremely anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, **how depressed** (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed — Extremely depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have **you felt your work** (both inside & outside the home) has affected (or would affect) your pain?

   Have not made it worse — Have made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been **able to control** (reduce/help) your pain/discomfort on your own?

   Completely control it — No control whatsoever

   0 1 2 3 4 5 6 7 8 9 10

Patient Signature **Total Score**

With Permission from Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck/Back pain Patients *JMPT* 2002; 25 (3): 141-148

Treatment History Post-Collision:

1.) Dr.:_____
Specialty: _____
Date 1st seen: _____
Referred by: _____
Treatment Type: _____
Treatment Frequency_____
Treatment Duration _____
Currently treating? ○ Yes ○ No
Any disability? ○ Yes ○ No
If yes, describe: _____
Special tests:_____
Referred to: _____
Did treatment help? ○ Yes ○ No
Notes:_____

2.) Dr.: _____
Specialty: _____
Date 1st seen: _____
Referred by: _____
Treatment Type: _____
Treatment Frequency_____
Treatment Duration _____
Currently treating? ○ Yes ○ No
Any disability? ○ Yes ○ No
If yes, describe_____
Special tests: _____
Referred to: _____
Did treatment help? ○ Yes ○ No
Notes:_____

ER Hospital Name_____
X-Rays: ○ Yes ○ No
Body parts imaged_____
Results_____
Other Imaging: ○ Yes ○ No
Type of Imaging: _____
Body parts imaged_____
Results_____

☐ Cervical Collar ☐ Ice
☐ Medications _____

Fractures: _____
Cuts: _____
Bruises: _____
Confined in hospital for: _____days/_____ hours

Please fill out all applicable fields:

List any traumas and their dates (especially any head and neck injuries): _____
_____
_____
_____
_____
_____

List any broken bones or dislocations: _____
_____
_____
_____
_____
_____

List all surgeries and their dates: _____
_____
_____
_____
_____
_____

Have you ever been unconscious, if so please explain:
_____
_____
_____
_____
_____

List any other doctors seen, treatments, and results obtained:
_____
_____
_____
_____
_____