Motor Vehicle Accident Report

Holladay Physical Medicine/ Personal Injury Clinic

NAME: _____ TODAY'S DATE:_____

THE VEHICLE IN WHICH YOU WERE RIDING:
INSURED'S NAME:_____
ADDRESS:_____ CITY_____ ST _____ZIP_____
BIRTH DATE:_____ PHONE #_____
MOTOR VEHICLE INSURANCE CO:_____ PHONE _____
ADDRESS:_____ CITY_____ ST _____ZIP_____
POLICY#_____ CLAIM # _____
AGENT'S NAME: _____PHONE:_____
ADJUSTOR'S NAME: _____PHONE_____

THE OTHER VEHICLE (IN WHICH YOU WERE NOT RIDING:
INSURED'S NAME:_____
ADDRESS:_____ CITY_____ ST _____ZIP_____
BIRTH DATE:_____ PHONE #_____
MOTOR VEHICLE INSURANCE CO:_____ PHONE _____
ADDRESS:_____ CITY_____ ST _____ZIP_____
POLICY#_____ CLAIM # _____
AGENT'S NAME: _____PHONE:_____
ADJUSTOR'S NAME: _____PHONE_____

Are you being represented by an attorney in this case?
NAME: _____ PHONE_____
ADDRESS:_____ CITY_____ ST _____ZIP_____

HISTORY OF PRESENT ILLNESS
Is this your first episode of pain? Yes ____ No ____
If no: number of previous episodes? _____
Last episode ended?_____
month/year
pain since last episode?_____
Were you injured? Yes _____ No ____
How did the injury occur? _____Motor vehicle accident

ACCIDENT/INJURY INFORMATION
Date of accident:
Time of accident:
Details of accident:

Describe your position in the vehicle on impact:
Describe impact direction and est. speed:
Were you the driver?:

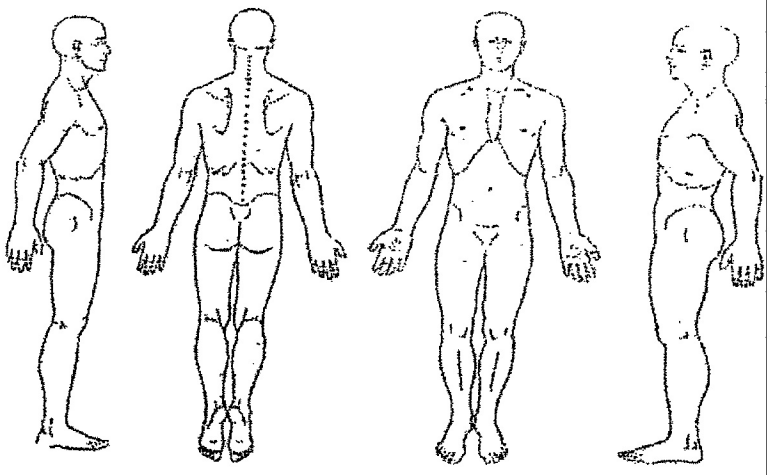
Size of your vehicle:
Size of the other vehicles:
Describe damage to the vehicles:
Describe in detail, all complaints and symptoms resulting from this injury/accident:

If work-related, date/time you had to leave work:
Workdays missed to date:
Have you notified your insurance company?

PAIN DRAWING

Please mark the figures to the right with the following:

////////// **Stabbing**
XXXX Burning
000000 Pins and Needles
====== Numbness
++++++ **Aching**
^^^^^^ **Other**



PROBLEM LIST:
Please summarize what problem(s) brought you to visit our office. (You may check more than one category).

PROBLEM	DATE PROBLEM STARTED
_____Headaches	_____
_____Neck pain	_____
_____Left Arm Pain	_____
_____Mid-Back Pain	_____
_____Lower Back Pain	_____
_____Left Leg Pain	_____
_____Right Arm Pain	_____
_____Right Leg Pain	_____
_____Other	_____

YOUR SYMPTOMS:
With this present episode of pain, was the onset gradual or sudden?

Please indicate how each of the following effects your pain by using - for decreases, + for increases, 0 for no difference and ? for don't know.

_____ walking	_____ sleeping	_____ Sexual activities
_____ sitting	_____ fatigue	_____ bending

_____ standing	_____ tension	_____ working
_____ reclining	_____ exercise	_____ housecleaning
_____ coughing	_____ sneezing	_____ bowel movements
_____ alcohol	_____ lifting	_____ medications

_____ others _____

What aspect of your pain, or which pain, is the most bothersome to you and why?

Do you have any associated symptoms such as headaches, nausea, or vomiting?

How often do you have to stop your activities and sit down or lie down to control your pain?
_____occasionally _____approximately once per day _____several times each day

_____I spend almost all day lying or sitting to control my pain.

PAIN RATION

At this time, which item best describes the ratio between pain in your neck/arm or back/leg (if applicable)?

For Neck Pain

____a. 100% neck pain; 0% arm pain
____b. 75% neck pain; 25% arm pain
____c. 50% neck pain; 50% arm pain
____d. 25% neck pain; 75% arm pain
____e. 0% neck pain; 100% arm pain

For Back Pain

____a. 100% back pain; 0% leg pain
____b. 75% back pain; 25% leg pain
____c. 50% back pain; 50% leg pain
____d. 25% back pain; 75% leg pain
____e. 0% back pain; 100% leg pain

PAIN DESCRIPTION:

SEVERITY OF PAIN: On a scale of 0 to 10 with 0 representing no pain whatsoever while 10 would be the most severe pain imaginable (suicidal pain), which number would describe your pain:

What is your pain like today?	0 1 2 3 4 5 6 7 8 9 10
What is your least pain?	0 1 2 3 4 5 6 7 8 9 10
What is your worst pain?	0 1 2 3 4 5 6 7 8 9 10

How much time during an average day are you in pain?

____less than 1 hour per day
____between 1 and 4 hours per day
____between 4 and 8 hours per day
____almost anytime that I am not lying down.
____almost 24 hours per day

Mark with an "X" by the worst and best times of day for your pain:

Most Pain	Least Pain
_____ First Awakening	_____First Awakening
_____ Morning	_____ Morning
_____ Mid-day	_____ Mid-day
_____ Afternoon	_____ Afternoon
_____ Evening	_____ Evening
_____ Night time(falling asleep)	_____ Night time (falling asleep)
_____Time of day not related to pain	

PREVIOUS MEDICAL TREATMENT AND DIAGNOSTIC TESTS:
Please list all doctors (HOSPITALS, MDs, DCs, DOs, or therapists) you have seen for your problem and when you first saw them.

Date Person Seen Problem

_____
_____
_____
_____

Which of the following tests have you had?

	Yes	No	Date	Location	Results(if known)
Plan X-rays	___	___	_____	_____	
CT Scan	___	___	_____	_____	
Myleogram	___	___	_____	_____	
MRI Scan	___	___	_____	_____	
Discogram	___	___	_____	_____	
Bone Scan	___	___	_____	_____	
EMG	___	___	_____	_____	
Thermogram(TG)	___	___	_____	_____	
Other	___	___	_____	_____	

Have you had any of these treatments? were there benefits? What:

Treatment	Helped	Worse	Neither	COMMENTS:
1. Hot Packs	____	____	_____	_____
2. Ultrasound	____	____	_____	_____
3. Ice	____	____	_____	_____
4. Massage	____	____	_____	_____
5. Electrical stimulation	____	____	_____	_____
6. TENS Unit for home use	____	____	_____	_____
7. Body mechanics training	____	____	_____	_____
8. Strengthening exercises	____	____	_____	_____
9. Aerobics (exercise bike)	____	____	_____	_____
10. Gravity inversion	____	____	_____	_____
11. Traction	____	____	_____	_____
12. Bed Rest	____	____	_____	_____
13. Chiropractic manipulative therapy	____	____	_____	_____
14. Biofeedback	____	____	_____	_____
15. Local trigger point injections	____	____	_____	_____
16. Epidural injections	____	____	_____	_____
17. Facet joint injections	____	____	_____	_____
18. Back brace / neck brace	____	____	_____	_____
19. Acupuncture	____	____	_____	_____
20. Anti-inflammatory med.	____	____	_____	_____
21. Narcotic pain med.	____	____	_____	_____
22. Muscle relaxant med.	____	____	_____	_____
23. Anti-depressant med.	____	____	_____	_____
24. Other	____	____	_____	_____

Are you currently getting any treatments listed above? yes_____ no_____

If yes, which one(s) and frequency of treatment?

If you are not getting any of the treatments listed above, approximately when is the last time you did get any of them?

MEDICATIONS:

Please list all medications you take--even if only occasionally. Include how often you take the medication, how much you take, and/or how long you have taken it. Please note any aspirin, Tylenol or vitamins you might take as well.

Medications How Often How Much For How Long What For

VITAMINS – MINERALS – HERBS – HOMEOPATHIC REMEDIES – OTHERS

Item How Often How Much For How Long What For

FUNCTIONAL HISTORY:

Please note how long you can presently (in minutes or hours):

Sit continuously: _____ Drive continuously: _____

Stand continuously: _____ Walk continuously: _____

Number of pounds lifted per hour: _____

ACTIVITIES OF DAILY LIVING'S:

Do you have difficulty with:

Dressing: yes_____ no_____

If yes please specify_____

Personal hygiene: yes____ no_____

If yes, please specify_____

House/yard work: yes_____ no_____

If yes, please specify_____

Preparing meals: yes_____ no_____

If yes, please specify_____

RECREATIONAL ACTIVITIES:

List some of the hobbies or recreational activities you enjoyed prior to your pain. Please put an "X" by those activities you can no longer enjoy because of your pain.

___1)_____ ___5)_____

___2)_____ ___6)_____

___3)_____ ___7)_____

___4)_____ ___8)_____

EXERCISE:

Are you currently doing any daily exercise or stretching? yes_____ no_____

If yes, how often? _____ How much time for each session? _____

Describe your routine _____

COMMENTS:

If there is anything else you feel the doctor should know? If you have anything else to add, please feel free to do so.

I certify that the statements made herein are true to the best of my knowledge:

_____ DATE: _____

Signature

Notice to Insurance Company of Assignment

Date:_____

TO: _____ (Ins. Co)

_____

Policy No:_____

_____

Claim No: _____

You are hereby instructed to pay directly to the doctor at his office for all professional services rendered to me by his office. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Also, I am personally liable for any unpaid accounts for hospital, diagnostic and consultant services

I hereby authorize the doctor listed below to furnish you the information and evidence in their possession regarding my history and physical condition.

Please Remit To:

Holladay Physical Medicine
The Personal Injury Clinic
Dr. Bruce Gundersen
4211 Holladay Blvd
Holladay, UT 84124
Tel 801-272-8471

Patient's Signature: _____

Patient's Name (Printed) _____

Address: _____

* Notice: Most insurance companies will send you out information regarding your claim, this is usually called "Application for No Fault Benefits". This form MUST to be filled out by you, a copy provided to us and one sent back to your insurance company of they will not pay your bill. If you have any questions, please feel free to ask any of us at the office!

Thanks for your cooperation!