History of Present Illness for Motor Vehicle Accidents

Last Name: ______________________________ First Name: ______________________________

Date of Birth: ______________________________ Today's Date: ______________________________

Current Height: ___________ **Have you had a bone density scan (for osteoporosis)?** ❑ Yes ❑ No

Current Weight: ___________ **Where/Year:** ______________________________

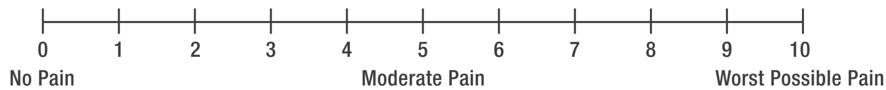
Laterality: ❑ **Right** ❑ **Left** ❑ **Bilateral**

❑ **Fracture**
❑ **Laceration/Wound**

Primary Affected Area: *Choose most significant area for today's visit*

❑ Neck ❑ Mid Back ❑ Low Back ❑ Shoulder ❑ Clavicle ❑ Upper Arm ❑ Elbow ❑ Forearm
❑ Wrist ❑ Hand ❑ Hip ❑ Pelvis ❑ Thigh ❑ Knee ❑ Lower Leg ❑ Ankle ❑ Foot

On a scale of 0 to 10, 0 being no pain and 10 being the worst, please circle below your current level of pain



Signs & Symptoms: ❑ Bruising ❑ Numbness/tingling ❑ Stiffness ❑ Weakness ❑ Swelling

Aggravated By: ❑ Daily Activities ❑ Exercise ❑ Lifting ❑ Overhead ❑ Motion ❑ Sports ❑ Throwing ❑ Work

Relieved By: ❑ Activity ❑ Compression Wrap ❑ Elevation ❑ Heat ❑ Ice ❑ Injections ❑ NSAIDs ❑ Pain Medication
❑ Physical Therapy ❑ Rest ❑ Tylenol ❑ I do not get relief

Pain Is: ❑ Dull ❑ Sharp ❑ Throbbing ❑ Intermittent ❑ Constant

Date of Accident: ____________________ **Place:** ❑ Highway ❑ Private Road ❑ Residential Road ❑ Public Road ❑ Parking Lot

Please explain place where accident occurred: ______________________________

❑ Traffic Accident ❑ Non-Traffic Accident | ❑ Pedestrian ❑ Driver ❑ Passenger | ❑ Restrained ❑ Non-Restrained

Vehicle you were in: ❑ Auto ❑ Motorcycle ❑ Off Road ❑ Pick-up Truck ❑ Truck ❑ Van

Other vehicle involved: ❑ Auto ❑ Motorcycle ❑ Off Road ❑ Pick-up Truck ❑ Truck ❑ Van

Do you have an immediate or previous history of falls? ❑ Yes ❑ No

Do you use an assistive device to help you ambulate? ❑ Yes ❑ No

If yes, please check the most appropriate device: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Rolling Scooter ❑ Other: ___________

I certify that the statements provided are true and correct and provided to the best of my ability.

Patient/Guardian's Signature ______________________ Clinical Staff's Initials ______________________

Medications You Are Currently Taking

Today's Date: ____________________

Patient Name: ________________________________ Date of Birth: ____________________

List all medications you are taking including non-prescription medications and opioids ❑ I am not taking any medications

	Medication #1	Medication #2	Medication #3	Medication #4
Name:				
Dosage:				
Frequency:				
Route:	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops
	Medication #5	Medication #6	Medication #7	Medication #8
Name:				
Dosage:				
Frequency:				
Route:	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops
	Medication #9	Medication #10	Medication #11	Medication #12
Name:				
Dosage:				
Frequency:				
Route:	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops
Preferred Pharmacy:	Name: ______________________________		Address: ______________________________	

Clinical Staff's Initials ____________________________