RAPID Doc Documentation

## INITIAL EVALUATION – Automobile Accident

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

What brings you into our office? ☒ **Automobile Accident**

When did this accident happened? _____

What was your position in the vehicle?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger
☐ Middle Front Passenger ☐ Middle Rear Passenger ☐ Right Rear Passenger

What was the damage to the vehicle? ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled

How was the visibility on the road? ☐ Poor ☐ Fair ☐ Good

And the weather was:

☐ Clear ☐ Raining ☐ Windy ☐ Foggy ☐ Snowing

How did the accident happen?

☐ You hit another vehicle ☐ Another vehicle hit you ☐ You hit another object

What was the point of impact on our vehicle?

☐ Left ☐ Front end ☐ Rear End ☐ Right
☐ Left front ☐ Left rear ☐ Right front ☐ Right rear

Did you see the accident coming? ☐ Yes ☐ No

Were you braced for the impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, Does the seatbelt have a shoulder strap? ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No

Did it deploy during the accident? ☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No
If yes, positioned: ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

Did you strike anything inside the vehicle? ☐ Yes ☐ No

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What inside your vehicle id you strike? ☐ Wheel ☐ Windshield ☐ Arm rest ☐ Dashboard
☐ Side Door ☐ Side window ☐ Airbag

Immediately after the accident, did you feel dazed? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Which way was your head turned during the accident?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Was your head injured? ☐ Yes ☐ No

Immediately after the accident, did you experience: ☐ Headache ☐ Neck Paid ☐ Low Back Pain

Did you see another doctor before coming here? ☐ Yes ☐ No

Did you go to a hospital after the accident? ☐ Yes ☐ No If yes, which hospital? _____

How did you get to the hospital? ☐ Ambulance ☐ Drove self ☐ Somebody else ☐ Police

Were any of the following tests performed at the hospital?
☐ X-Rays ☐ MRI ☐ CT Scan ☐ Lab Work

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting Worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities: ☐ Yes ☐ No
If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

## INITIAL EVALUATION – Automobile Accident

**Activities of Daily Living** *Please select all activities which you are currently experiencing problems:*

| | | | | | |
|---|---|---|---|---|---|
| ☐ Seeing | ☐ Tasting | ☐ Smelling | ☐ Eating | ☐ Hearing | ☐ Insomnia |
| ☐Dressing | ☐Reading | ☐Typing | ☐Writing | ☐Grasping | ☐ Using the toilet |
| ☐ Standing | ☐ Leaning | ☐ Walking | ☐ Stooping | ☐ Squatting | ☐ Loss of Sexual Drive |
| ☐ Bending | ☐ Twisting | ☐ Carrying | ☐ Lifting | ☐ Pushing | ☐ Restful sleeping |
| ☐ Sitting | ☐ Driving | ☐ Sports | ☐ Exercising | ☐ Reclining | ☐ Loss of concentration |
| ☐ Irritable | ☐ Riding in car | ☐ Air Travel | ☐ Climbing | ☐ Pulling | ☐ Changes in personality |
| ☐ Grooming | ☐ Pinching | ☐ Kneeling | ☐ Reaching | ☐ Nervous | ☐ Tactile feeling |
| ☐ Bathing | ☐ Holding | | | | |

**Past Medical History** *Please select all conditions that you have had or are currently having:*

| | | | | |
|---|---|---|---|---|
| ☐None | ☐Other | ☐Abdominal pain | ☐Abnormal Weight gain/loss | ☐Angina |
| ☐Anorexia | ☐Anxiety | ☐Aortic aneurysm | ☐Arthritis | ☐Asthma |
| ☐Bladder infection | ☐Blood disorder | ☐Brest lumps | ☐Breast Soreness | ☐Bronchitis |
| ☐Cancer | ☐Cardiovascular disease/heart attack | ☐Chest pain | ☐Chronic cough | ☐Chronic sinusitis |
| ☐Colitis | ☐Constipation | ☐Convulsions | ☐COPD | ☐Depression |
| ☐Dermatitis, Eczema/Rash | ☐Diabetes | ☐Difficulty in swallowing | ☐Dizziness | ☐Emphysema |
| ☐Endometriosis | ☐Epilepsy | ☐Excessive thirst | ☐Fainting | ☐Frequent urination |
| ☐General fatigue | ☐Gout | ☐Hand pain | ☐Headache | ☐Heart attack |
| ☐Heart disease | ☐Heartburn/Indigestion | ☐Hepatitis | ☐High Blood Pressure | ☐High cholesterol |
| ☐High PSA | ☐High triglycerides | ☐Hypertension | ☐Irregular menstrual flow | ☐Irritable colon |
| ☐Jaw pain | ☐Kidney disorders | ☐Kidney stones | ☐Liver/Gallbladder problems | ☐Loss of appetite |
| ☐Loss of bladder control | ☐Low back pain | ☐Lung Disease | ☐Mental Disease | ☐Mid back pain |
| ☐Muscular in coordination | ☐Neck pain | ☐Osteoarthritis | ☐Pain in ankle or foot | ☐Pain in lower leg or knew |
| ☐Pain in upper arm or elbow | ☐Pain in upper leg and hip | ☐Painful urination | ☐PMS | ☐Pneumonia |
| ☐Profuse menstrual flow | ☐Prostate problems | ☐Rapid heart beat | ☐Renal Disease | ☐Theumatiod arthritis |
| ☐Scoliosis | ☐Shoulder pain | ☐Stroke | ☐Swelling/stiffness of joints | ☐Thyroid disease |
| ☐Tinnitus (ear noices) | ☐Tuberculosis | ☐Tumor | ☐Ulcer | ☐Visual disturbances |
| ☐Wrist pain | | | | |

## INITIAL EVALUATION – Automobile Accident

**Family History** *Please select all conditions that run in your family:*

| | | | | |
|---|---|---|---|---|
| ☐None | ☐Other | ☐Abdominal pain | ☐Abnormal Weight gain/loss | ☐Angina |
| ☐Anorexia | ☐Anxiety | ☐Aortic aneurysm | ☐Arthritis | ☐Asthma |
| ☐Bladder infection | ☐Blood disorder | ☐Brest lumps | ☐Breast Soreness | ☐Bronchitis |
| ☐Cancer | ☐Cardiovascular disease/heart attack | ☐Chest pain | ☐Chronic cough | ☐Chronic sinusitis |
| ☐Colitis | ☐Constipation | ☐Convulsions | ☐COPD | ☐Depression |
| ☐Dermatitis, Eczema/Rash | ☐Diabetes | ☐Difficulty in swallowing | ☐Dizziness | ☐Emphysema |
| ☐Endometriosis | ☐Epilepsy | ☐Excessive thirst | ☐Fainting | ☐Frequent urination |
| ☐General fatigue | ☐Gout | ☐Hand pain | ☐Headache | ☐Heart attack |
| ☐Heart disease | ☐Heartburn/Indigestion | ☐Hepatitis | ☐High Blood Pressure | ☐High cholesterol |
| ☐High PSA | ☐High triglycerides | ☐Hypertension | ☐Irregular menstrual flow | ☐Irritable colon |
| ☐Jaw pain | ☐Kidney disorders | ☐Kidney stones | ☐Liver/Gallbladder problems | ☐Loss of appetite |
| ☐Loss of bladder control | ☐Low back pain | ☐Lung Disease | ☐Mental Disease | ☐Mid back pain |
| ☐Muscular in coordination | ☐Neck pain | ☐Osteoarthritis | ☐Pain in ankle or foot | ☐Pain in lower leg or knew |
| ☐Pain in upper arm or elbow | ☐Pain in upper leg and hip | ☐Painful urination | ☐PMS | ☐Pneumonia |
| ☐Profuse menstrual flow | ☐Prostate problems | ☐Rapid heart beat | ☐Renal Disease | ☐Theumatiod arthritis |
| ☐Scoliosis | ☐Shoulder pain | ☐Stroke | ☐Swelling/stiffness of joints | ☐Thyroid disease |
| ☐Tinnitus (ear noices) | ☐Tuberculosis | ☐Tumor | ☐Ulcer | ☐Visual disturbances |
| ☐Wrist pain | | | | |

## Surgical History

*Please select all surgeries that you have had in the past.*

| | | | | |
|---|---|---|---|---|
| ☐ None | ☐ Other | ☐ Abdominal Exploration | ☐ Abdominoplasty | ☐ Abortion |
| ☐ ACL Reconstruction | ☐ Adenoid Removal | ☐ Angioplasty | ☐ Appendectomy | ☐ Bone Fracture Repair |
| ☐ Breast Lump Removal | ☐ Bunion Remova | ☐ Carotid Artery Surgery | ☐ Cataract Surgery | ☐ Cervical spine Surgery |
| ☐Cholecystectomy | ☐ Cosmetic Breast Burgery | ☐ C-Section | ☐ Facelit | ☐ Gallbladder Removal |
| ☐ Gastric Bypass | ☐ Heart Bypass Surgery | ☐ Heart Surgery | ☐ Hemorrhoid Surgery | ☐ Hernia Repair |
| ☐ Hip Joint Replacement | ☐ Hysterectomy | ☐ Kidney Transplant | ☐ Knee Arthroscopy | ☐ Knee Joint Replacement |
| ☐ Knee surgery | ☐ LASIK Eye Surgery | ☐ Liposuction | ☐ Lumbar spine surgery | ☐ Mastectomy |
| ☐ Prostate Removal | ☐ Rotator Cuff Surgery | ☐ | ☐ TMJ Surgery | ☐ Tonsillectomy |
| ☐ Vasectomy | ☐ Surgical History was rev'd not contributory | | | |

## Medications

*Please select all medications that you are currently taking:*

| | | |
|---|---|---|
| ☐ None | ☐ Other | ☐ Advil |
| ☐ Ambien | ☐ Analgesics | ☐ Anti-inflammatories |
| ☐ Aspirin | ☐ Atenolol | ☐ Blood Pressure Medication |
| ☐ Daily Vitamins | ☐ Diabetes Medication | ☐ Flexeril |
| ☐ Isorsubrine | ☐ Monopril | ☐ Motrin |
| ☐ Muscle relaxers | ☐ Pin Medication | ☐ Skelaxin |
| ☐ Synthroid | ☐ Tylenol | ☐ Vicodin |

## Allergies

*Please select all items that you are allergic to:*

| | | | | |
|---|---|---|---|---|
| ☐ None | ☐ Other | ☐ Adhesive tape | ☐ Animal dande | ☐ Anticonvulsants |
| ☐ Barbiturates | ☐ Bee stings | ☐ Dirt | ☐ Dust mites | ☐ Eggs |
| ☐ Feathers | ☐ Felt tip pens | ☐ Fire ant stings | ☐ Fish | ☐ Gasoline fumes |
| ☐ Hair Spray | ☐ Histamine | ☐ Hornet stings | ☐ Insecticides | ☐ Insulin |
| ☐ Iodine | ☐ Latex | ☐ Milk | ☐ Mold | ☐Nail polish remover |
| ☐ New Carpet | ☐ Newspaper ink | ☐ Paint or paint thinner | ☐ Peanuts | ☐ Penicillin |
| ☐ Perfume | ☐ Pets | ☐ Pollen | ☐ Pool Chlorine | ☐ Seafood |
| ☐ Shampoo | ☐ Shellfish | ☐ Smoke | ☐ Soy | ☐ Sulfa Drugs |
| ☐ Tobacco smoke | ☐ Tree nuts | ☐ Wasp Stings | ☐ Wheat | ☐Yellow jacket stings |

## Social History

*Please answer the following questions:*

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee