VAN WORMER HEALTHCARE CLINIC ● 2850 MANHATTAN BLVD. STE A HARVEY, LA 70058 ● (504) 362-3000 ● WWW.DRVANWORMER.COM

PATIENT- BLACK INK STAFF-RED INK DOCTOR-BLUE INK

# INCIDENT INFORMATION FORM

Date of this Incident: _____ Time of Incident: _____am/pm

Did you report this incident? Yes / No Do you have a Police Report? Yes / No

At the time of collision were you: Stopped / Slowing / Accelerating / Moving with traffic

Road Conditions: Dry / Wet / Other _____

Collision type:Head-on / Rear-end / Front-end T-bone or Side- swipe: Driver's Side/ Passenger's side

Was there more than one impact? Yes/No

Did you see the impact coming? Yes / No Did you brace for the impact? Yes/ No

Were you the Driver/ Front Passenger/ Backseat (Driver side/ Middle/ Passenger side)

Seat Belt: Wearing / Not Wearing Headrest: Above head/ Middle of head/ Below head

Head/Body Position just before impact:

( ) Head straight forward ( ) Body straight in sitting position
( ) Head looking back ( ) Body rotated left/right
( ) Head turned left/right ( ) Body leaning on console or door

Did your head or body strike any parts of the vehicle? Yes / No Describe: _____

Did the air bag deploy? Yes/ No If yes, did it strike you? Where _____

Who was in the vehicle with you? _____

Your vehicle (model& year):_____

Other vehicle (model & year):_____

Is this your first motor vehicle collision EVER? Yes/ No Date of last incident:_____

Did your vehicle strike any objects: Yes/ No If yes, what? _____

Did you experience: Blurred vision? Yes / No Ringing in the ears? Yes / No
Dizziness? Yes / No Loss of consciousness? Yes/ No

Did you go to the hospital after the incident? Yes / No If yes, what hospital _____
By ambulance? Yes / No
Have you seen any other doctors? Yes / No Who? _____
Were X-Rays taken? Yes / No If yes, what X-Rays?_____
Were medications given? Yes / No If yes, what medications? _____

Since the incident, have you had any:
Bruising: Yes/ No If yes, where? _____ Cuts: Yes/ No If yes, where? _____
Fractures: Yes/ No If yes, where? _____ Difficulty (sitting / standing / lying) since the incident? Yes/ No

## WORK STATUS

Have you missed any work since the incident? Yes / No If yes, how many days? _____
Have you returned to work? Yes/ No With restrictions? Yes/No If yes, describe _____

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# MEDICAL HISTORY

Primary care physician_____ Phone # _____

Have you been treated for any health condition by a physician in the last year? Yes/ No If yes, explain_____

_____

Have you EVER been treated for back or neck issues? _____

Please date & describe any Surgeries/Fractures/Falls/Other Incidents: _____

_____

If you are female, are you possibly pregnant? Yes/No Date of last menstrual cycle_____

Do you or a family member have of any of the following:

Diabetes/ Stroke/ Cancer/ Heart Condition/ High Blood Pressure/ Psychological disorders

Other: _____

Relation: _____

Please list any & all medications you are taking (include over the counter):

Name & Medication Instructions:_____

_____

_____

| | None | Light | Moderate | Heavy |
|---|---|---|---|---|
| Exercise | | | | |
| Smoke | | | | |
| Drink Alcohol | | | | |
| Experience stress | | | | |

# Present Complaint(s)

Name: _____Date:_____

When did the pain start? _____

How did the pain start? _____

Did you see your primary doctor or go to an emergency room? _____

**Please check ALL that apply to your current condition:**

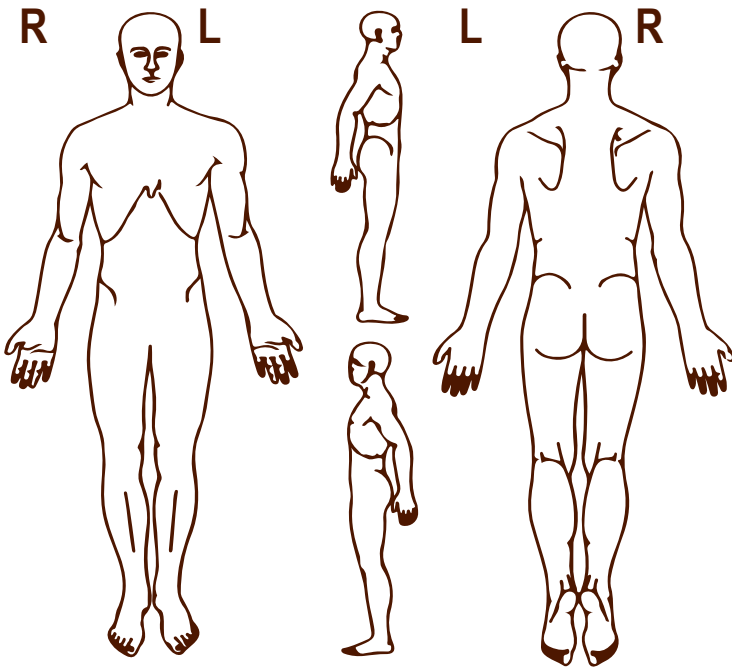
| | | |
|---|---|---|
| _____Headaches | _____Vision Problems (R L B) | _____Nausea |
| _____Neck Pain | _____Hearing Problems (R L B) | _____ Difficulty Swallowing |
| _____Upper Back Pain | _____Dizziness | _____Confusion |
| _____Mid Back Pain | _____Irritability | _____Facial TMJ (R L B) |
| _____Lower Back Pain | _____Fatigue | _____Other_____ |
| _____Pelvis/Chest/Abdomen Pain | _____Anxiety/Depression | |

| | | | |
|---|---|---|---|
| _____ Shoulder/Arm/Forearm/Elbow Pain | ❑ Right | ❑ Left | ❑ Both |
| _____ Wrist/Hand/Finger Pain | ❑ Right | ❑ Left | ❑ Both |
| _____ Hip/Thigh/Knee/Leg Pain | ❑ Right | ❑ Left | ❑ Both |
| _____ Ankle/Foot/Toe Pain | ❑ Right | ❑ Left | ❑ Both |

Is the pain worse when you cough or sneeze? Yes / No Has it disturbed your sleep? Yes / No

Has it affected any other systems? Yes / No Urinary / Bowel / Cardiac / Respiratory / Vision

Has the pain affected: ❑ Work ❑ Hobbies ❑ Relationships ❑ Household Chores




## SHOW US WHERE YOU HURT

**Please read carefully:**

Using the drawings on the left, mark the areas on your body where you feel pain. Include ALL affected areas. If your pain radiates, draw an arrow from where it starts to where it stops, extending the arrow as far as the pain travels.

***Use the appropriate symbols listed below.***

| | | |
|---|---|---|
| Ache >> | Numbness == | Pins & Needles oo |
| >> | == | oo |
| Burning xx | Stabbing // | Throbbing ~~ |
| xx | // | ~~ |

# PATIENT INFORMATION

Last Name: _____ First Name: _____ Sex: M / F

Address: _____ City: _____ State: ___ Zip: _____

Home Phone _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: ____ Marital Status: Single Married Divorced Widowed

Social Security #: _____-_____-_____ Driver's License #: _____

Emergency Contact: _____ Relation: _____

Emergency Contact #:_____

**HOW DID YOU HEAR ABOUT US?** _____

## Employed / Unemployed / Student / Homemaker

Employed by: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip:_____

## Attorney's Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip:_____

## Insurance of person at fault: _____ Phone # _____

Insured's Name: _____ Phone # _____

Address:_____ City:_____ State: _____ Zip: _____

Policy # _____ Claim # _____

## Your Auto Insurance Co.: _____ Phone # _____

Insurance Company:_____ Policy#:_____ **Claim #:** _____

## Health Insurance: _____ Phone #: _____

Policy#: _____ Group # _____

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balance at the time of services, and I authorize direct payment from my insurance company or attorney to this office. I understand that I am personally responsible for any remaining balance this office does not collect regardless of settlement from any lawsuit or insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and 25% attorney's fees.

Signature_____ Date_____

Louisiana Law requires physicians and other healthcare providers to make certain disclosures to a patient when they refer a patient to another healthcare provider or facility in which the physician has a significant financial interest. If medically necessary, I may refer you, or the named patient for whom you are a legal representative to: Injury Treatment Center New Orleans, 3714 Airline Drive, Metairie, LA 70001. I, George Van Wormer DC, have a significant financial interest in the healthcare provider to whom we are referring you. I, the below named patient, or legal representative, hereby acknowledge receipt of a copy of the foregoing Disclosure of Financial Interest.

_____ _____

Print Patient's Name Signature of Patient Date