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 _____
Did this incident happen while at work? Yes/No _____

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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:

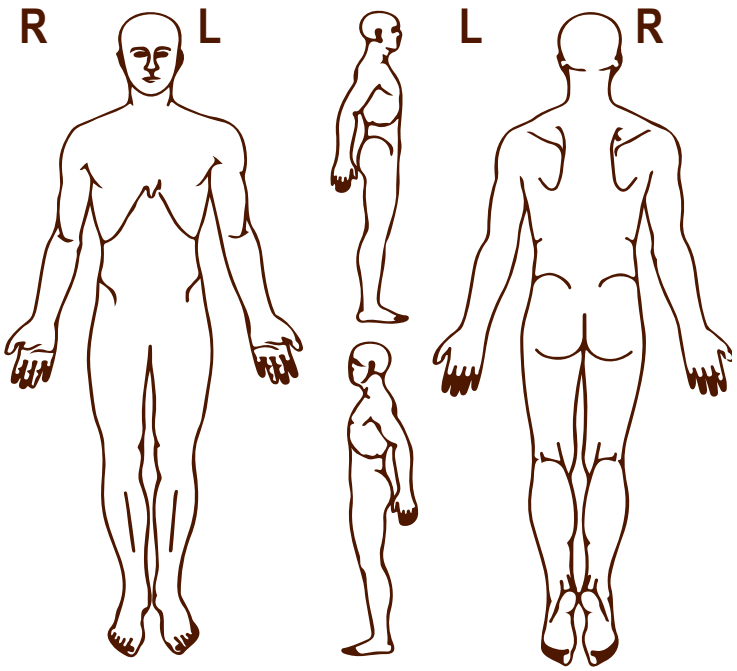
_____Headaches	_____Vision Problems (R L B)	_____Nausea
_____Neck Pain	_____Hearing Problems (R L B)	_____ Difficulty Swallowing
_____Upper Back Pain	_____Dizziness	_____Confusion
_____Mid Back Pain	_____Irritability	_____Facial TMJ (R L B)
_____Lower Back Pain	_____Fatigue	_____Other_____
_____Pelvis/Chest/Abdomen 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 & oo
>>	==	Needles 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 # _____

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_____