Patient: _____ **DOB:** _____

Accident: ☐ Automobile ☐ Bicycle ☐ Pedestrian ☐ Work **DOA:** _____

Describe the accident:

_____

_____

MVA

☐ Driver ☐ Front passenger ☐ Rear left passenger ☐ Rear right passenger ☐ Pedestrian ☐ Bicyclist

Wearing a seatbelt? ..... ☐ No ☐ Yes ➔
➔ Any bruises/marks from the seatbelt? ..... ☐ No ☐ Yes
Did you brace with hands for impact? ..... ☐ No ☐ Yes
Did you brace with feet for impact? ..... ☐ No ☐ Yes
Did you strike anything inside the vehicle at the time of impact? ☐ No ☐ Yes ➔
➔ If yes, what part of your body was injured? .. _____
➔ Any bruises/cuts from the impact? ..... ☐ No ☐ Yes
Did you hit your head? ..... ☐ No ☐ Yes
Did you pass out? ..... ☐ No ☐ Yes
Did you become dizzy, dazed, disoriented? ..... ☐ No ☐ Yes

Prior Treatment

Did the ambulance arrive? ..... ☐ No ☐ Yes ➔
➔ Did they take you to a hospital? ..... ☐ No ☐ Yes
Did you go to a hospital (urgent care) on your own? ..... ☐ No ☐ Yes ➔
➔ Was any medication prescribed? ..... ☐ No ☐ Yes
Has any imaging been done since the accident (X-ray, MRI, CT)? . ☐ No ☐ Yes
Have you completed or are undergoing rehabilitation? ..... ☐ Chiropractic ☐ PT ☐ Acupuncture ➔
➔ If yes, how are you feeling? ..... ☐ Improved ☐ No change ☐ Worse
Have you seen a medical doctor about this issue? ..... ☐ No ☐ Yes ➔
➔ If yes, specify: ..... ☐ PCP ☐ Neuro ☐ Ortho ☐ Pain management
Have you had any procedures? ..... ☐ No ☐ Yes ➔
➔ If yes, specify: ..... ☐ Injections ☐ Nerve blocks ☐ Other
➔ If yes, how are you feeling? ..... ☐ Improved ☐ No change ☐ Worse

Pertinent Medical History

Your overall health ..... ☐ Good ☐ Fair ☐ Poor
Hypertension (high blood pressure) ..... ☐ No ☐ Yes
Heart disease (arrhythmia, coronary heart disease, stents, pacemaker) ..... ☐ No ☐ Yes
Extremity swelling, lymphedema ..... ☐ No ☐ Yes
Diabetes (high blood sugar) ..... ☐ No ☐ Yes
Frequent skin infections, open wounds, propensity to form keloids ..... ☐ No ☐ Yes
Asthma, COPD ..... ☐ No ☐ Yes
Bleeding problems (bruising easily, blood thinners, thrombocytopenia, etc.) ..... ☐ No ☐ Yes
Immune deficiency (cancer, HIV, chemotherapy, neutropenia, etc.) ..... ☐ No ☐ Yes
Severe liver or kidney disease ..... ☐ No ☐ Yes
Osteoarthritis, autoimmune disease (Lupus, RA, etc.) ..... ☐ No ☐ Yes
Seizures, stroke, balance issues, inner ear problems ..... ☐ No ☐ Yes
Pregnant, breastfeeding ..... ☐ No ☐ Yes
Mental health issues (depression, anxiety, insomnia, etc.) ..... ☐ No ☐ Yes

Patient: _____ **DOB:** _____

Ongoing or Frequent Use of the Following?

Pain medications (Tylenol, Ibuprofen, Naproxen, Vicodin, Tramadol, etc.) …….. ☐ No ☐ Yes
Alcohol ……... ☐ No ☐ Yes
Antacids (Tums, Mylanta, Omeprazole, Pantoprazole, etc.) …….. ☐ No ☐ Yes
Antibiotics …….. ☐ No ☐ Yes
Blood thinners (Coumadin, Eliquis, Pradaxa, Xarelto, Aspirin, Plavix, etc.) …… ☐ No ☐ Yes
Cigarettes or other tobacco products …… ☐ No ☐ Yes
Recreational drugs ……... ☐ No ☐ Yes
Sleeping pills …… ☐ No ☐ Yes

Current medications

_____

_____

Drug allergies

☐ No ☐ Yes ➔

_____

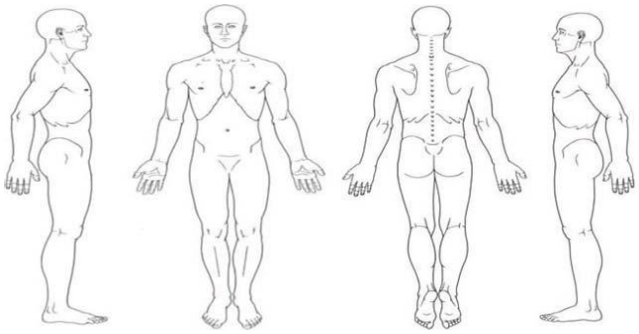
Surgical history

Surgery: brain, neck, back, hip, knee, shoulder, etc. …….. ☐ No ☐ Yes
Implants: artificial joints, breast implants, etc. …….. ☐ No ☐ Yes
Implanted electronic devices: pacemaker, defibrillator, vagus stimulator, etc. ……... ☐ No ☐ Yes
Heart surgery, prosthetic heart valves, vascular surgery …….. ☐ No ☐ Yes
Recent surgeries and/or invasive procedures, open wounds …….. ☐ No ☐ Yes

Symptoms – past 7 days

Circle or draw below your pain/symptoms (spasm, swelling, bruising, numbness, tingling, weakness, etc.):

Head
Jaw
Neck
Upper back
Mid back
Shoulder
Arm
Elbow
Wrist
Hand/fingers



Chest
Abdomen
Low back
Tailbone
Hip
Thigh
Knee
Ankle
Foot/toes

Pain Intensity (best and worse): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain Frequency: ☐ 100% (constant) ☐ 75% (frequent) ☐ 50% (intermittent) ☐ 25% (occasional) ☐ 0% (none)

What triggers/worsens your symptoms? ☐ Certain movements ☐ Standing ☐ Sitting ☐ Walking ☐ Sleeping ☐ Straining, coughing ☐ Stress

What improves your pain/symptoms? ☐ Physical therapy ☐ Chiropractic ☐ Medications ☐ Rest ☐ Movement ☐ Heat ☐ Ice ☐ Meditation, prayer

Pain interferes with: ☐ Ambulation ☐ Sleep ☐ Activities ☐ Work ☐ School ☐ Sports

Taken time off work/school due to pain? ☐ No ☐ Yes

Can you perform your daily activities? ☐ Yes, all activities ☐ Some activities ☐ Not at all

I hereby affirm that the information I have provided is current and correct to the best of my knowledge

_____ _____

Patient / Responsible party signature Date signed

NEW PATIENT: HISTORY & PHYSICAL EXAM

DOS: _____ Charting by Exclusion DOI: _____

_____ M F

Patient Name DOB

Time Temp HR SBP DBP Ht Wt Allergies

INJURY TYPE: -car Overturned Thrown from car Bicyclist Pedestrian **EXAM LIMITED:** Cognition Affect Pain HOH Language

HPI

Wearing seat belt	Y N	LOC / Dazed / Confused	Y N	**IMPACT**: (lines indicate impact)	
Airbags deployed	Y N	Dizziness / Balance lost	Y N	Head	Seat Headrest
Ambulated at scene	Y N	Memory loss	Y N	Face / Jaw	Steering wheel Airbag
Ambulance at scene	Y N	Cuts / Bruises / Abrasions	Y N	Chest / Abdomen	Seatbelt Windshield Dash
Police at scene	Y N	Visual loss / Seeing stars	Y N	UE	Door -Pillar
Taken to ER	Y N	Nause / Vomiting	Y N	LE	Center console Gear

PREVIOUS TREATMENT

Manipulation (DC, DO, ND)	Helped: ☐ Yes ☐ No	Continue: ☐ Yes ☐ No
Physical Therapy (PT)	Helped: ☐ Yes ☐ No	Continue: ☐ Yes ☐ No
Exercise Program	Helped: ☐ Yes ☐ No	Continue: ☐ Yes ☐ No
Injections	Helped: ☐ Yes ☐ No	Continue: ☐ Yes ☐ No
Acupuncture	Helped: ☐ Yes ☐ No	Continue: ☐ Yes ☐ No
Medications	Helped: ☐ Yes ☐ No	Continue: ☐ Yes ☐ No
Surgery	Helped: ☐ Yes ☐ No	Continue: ☐ Yes ☐ No

IMAGING

Reviewed

SUBJECTIVE

GENERAL	Dizziness ↓Balance Fatigue ↓Memory ↓Concentration Flashbacks Insomnia Anxiety Irritability		
HEAD	HA Facial tenderness Bruises Broken teeth Jaw pain Jaw clicking ↓Taste		
EENT	Eye pain Photophobia ↓Vision Floaters ↓Hearing Ear ringing Nasal trauma Nose Bleeds ↓Smell		
DERM / HEM	LACs Abrasions Bruises Seat belt marks Swelling Anticoagulation DVT Anemia		
NECK	Pain Stiffness Spasm	➔ **RADIATION**	Trap Shoulder Elbow FA Fingers
UP/MID BACK	Inter-scapular pain	**CHEST / ABD**	Palpitations Pain w/ breathing Bruising Abd pain N / V
LOW BACK	Pain Stiffness Spasm	➔ **RADIATION**	Buttocks Thigh Knee Calf Toes
UE	Shoulder Elbow Wrist Finger	**LE**	Hip Knee Ankle Toe

PAIN

FREQUENCY	Constant Frequent Intermittent Occasional Lasts hours minutes	**BEST LAST WEEK**	0 1 2 3 4 5 6 7 8 9 10
QUALITY	Dull Stabbing Sharp Burning Pounding Numbing Shooting	**WORST LAST WEEK**	0 1 2 3 4 5 6 7 8 9 10
WORSE ↑	Sitting Standing Walking Bending Turning Straining	**BETTER ↓**	Rest Movement Heat Ice Meds Therapy

Pain interferes with ☐ Ambulation ☐ Sleep ☐ Activities ☐ Family ☐ Sports ☐ Work ☐ School

SYSTEMS

GENERAL	N posture N speech	Visible discomfort Grimacing Guarding Restlessness Limping DME
SKIN	N color Intact	Erythema Rash Bruising Wound Abrasion Laceration Cool Clammy
HEAD	NCAT Scalp NT	Scalp tenderness Facial asymmetry Trauma evidence:
EYES	PERL EOMI Fields intact	Pupils unequal EOM palsy SCH Field loss
ENT	N inspect N voice N hearing	Ear canal blood Nasal passages blood Dental injury HOH
CHEST / ABD	NWOB No marks/bruises SNT	Tenderness Hernia

Patient _____ DOB _____

MSK

CS

UB/SHOULDER

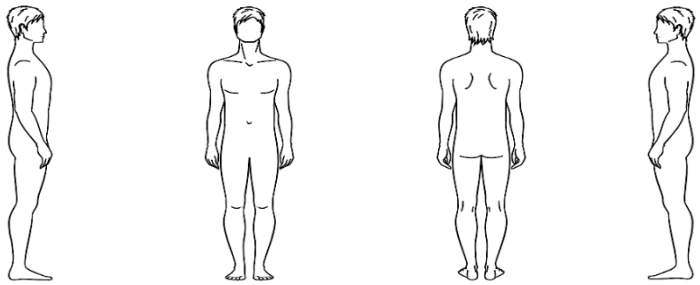
UE

TS

LS

PLV GIRDLE

LE



NL normal DF deformity SW swelling PM pain w motion MS spasm PR paresthesia WK weakness + or O positive, present
NT non-tender BR bruising DR DROM TD tenderness TP trigger point RD radiation I or ✓ (grossly) intact ⊖ or \ negative, absent

NEURO

GENERAL Cooperative No tremors CN grossly intact

GAIT N Limping Ataxic Antalgic Deliberate W/ assist

CEREB Balance N Coord N Romberg ⊖ F→N / H→S intact

MEMORY Recent intact Remote intact

MOTOR UE f-on preserved Heel/toe walk intact CST intact

SENSORY UE by touch intact LE by touch intact

SLR R: L: **DTR**

MENTAL Euthymic Dysphoric Labile Irritable Flat

ASSESSMENT

- ☐ Headaches (R51)
- ☐ Anxiety (F41.9)
- ☐ insomnia secondary to pain (G47.00)
- ☐ Cervical pain (M54.2)
- ☐ Cervical sprain/strain (S13.4xxA)
- ☐ Cervical radiculitis/neuritis (M54.12)
- ☐ **See attached form**
- ☐ Thoracic pain (M54.6)
- ☐ Thoracic sprain/strain (S233xxA)
- ☐ Trapezius sprain/strain (S46.81xA)
- ☐ Shoulder pain (M25.51)
- ☐ Elbow injury (M25.52)
- ☐ Wrist pain (M25.539)
- ☐ Chest wall pain (R07.89)
- ☐ Lumbar pain (M54.5)
- ☐ Lumbar sprain/strain (S33.5xxA)
- ☐ Lumbar radiculitis/neuritis (M54.16)
- ☐ Knee pain (M25.569)
- ☐ Ankle pain (M25.57)
- ☐ Disturbed sensation-paresthesia (R20.2)
- ☐ **Secondary to MVA (V49.9xxA)**

PLAN

- ☐ Conservative rehabilitation for 12-15 weeks to include chiropractic & other modalities
- ☐ Promote interventions emphasizing patient responsibility: therapeutic exercise / stretching at home, early return to activity, cognitive restructuring
- ☐ Detailed ortho / neuro examination by chiropractic
- ☐ Consider specialty evaluation (ortho, neurology, pain management, neurology, psychology) & additional imaging if not progressing
- ☐ Follow up w PCP to address chronic health issues
- ☐ Imaging
- ☐ Refer to
- ☐ Obtain medical records

RX

☐ Anti-inflammatory to ↓ soft tissue inflammation & pain:	PMP verified
☐ Antispasmodic to ↓ muscle hypertonicity & improve sleep:	Rx electronic paper (see attached)
☐ Opioid for short term relief of extreme pain:	None
☐ DME: Cervical pillow Back brace Ice pack	OTC

Potential SE of meds explained to pt. These include, but are not limited to, nausea, vomiting, diarrhea, bleeding, drowsiness, impaired mentation, & habit formation.

INSTRUCTED Dx Tx Compliance Rx AE R&B Referrals LSM Stress reduction

CONDITION Stable Unstable Urgent

NOTICE OF EMERGENCY MEDICAL CONDITION This patient, in my opinion, has suffered an *Emergency Medical Condition* d/t the injuries sustained in an automobile accident. The patient exhibits acute symptoms, including severe pain. The absence of immediate medical attention could reasonably be expected to result in: a) serious jeopardy to patient health; b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

RTC _____, sooner if sx worsen

I hereby attest that I am a physician, dentist, PA, or APRN licensed under chapters 458, 459, or 466, and that the above evaluation is true and correct to the best of my knowledge.

SERVICES PROVIDED TODAY: ☐ New patient exam 99202 99203 99204 99205

I CONFIRM THAT I HAVE RECEIVED THE ABOVE SERVICES:

_____ Patient/Guardian Signature

_____ Date

_____ Medical Provider

PATIENT: _____ DOB: _____

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

1. The above injured patient, has in the opinion of this medical provider, suffered an Emergency Medical Condition as a result of the patient's injuries sustained in an automobile accident that occurred on

_____.

2. The basis for the finding of an Emergency Medical Condition is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

a) Serious jeopardy to the patient's health;
b) Serious impairment to bodily functions; or
c) Serious dysfunction of a bodily organ or part.

I hereby attest that I am a Physician licensed under Chapter 458 or Chapter 459, a Physician Assistant licensed under Chapter 458 or Chapter 459, or an Advanced Registered Nurse Practitioner licensed under Chapter 464, and the above facts are true and correct.

_____	_____	_____
Provider Name & Credentials	Provider Signature	Date