ADVANCED BACK & NECK PAIN CENTER
F-54 Omega Drive
Newark, DE 19713
302-368-1300
302-368-1695
www.advancedback.com

PATIENT INTERVIEW FORM

Patient: _____ Age: _____ Birth Date: _____

Time In: _____ Time Out: _____ Date of Accident: _____

Doctor: _____ Date Of Exam: _____

Sex: ☐ M ☐ F Marital Status: _____ Spouse Name: _____ # of Children: _____

Occupation: _____ Years: _____ Employer: _____

Are you or have you missed time from work? ☐Yes ☐ No Type of Work: ☐ Office ☐ Clerical ☐ Light ☐ Moderate ☐ Heavy Labor

Describe the type of work performed: _____

Were you on-the-job when the accident occurred? ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger ☐ Other _____

Vehicle was driven by: _____

Did your vehicle strike another vehicle? ☐ Yes ☐ No Did another vehicle strike your vehicle? ☐ Yes ☐ No

Were you struck from: ☐ Behind ☐ Front ☐ Driver's side ☐ Passenger's side ☐ other _____

Were traffic citations issued? To whom? ☐ You ☐ Driver of your vehicle ☐ Driver of other vehicle ☐ None

Were police at the scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No did accident occur on ☐ public or ☐ private property

Your vehicle was heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/highway)

The other car heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/highway)

Your Vehicle (Year, Make, Model): _____

Your speed at the moment of accident: ☐ Full Stop ☐ Slowing ☐ Accelerating ☐ Legal Limit

The other Vehicle (Year, Make, Model) _____

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____

Head restraints: ☐ None ☐ Integral Type ☐ Adjustable: ☐ Up ☐ Down ☐ Don't know

If adjustable, was the position altered by the accident? ☐ Yes ☐ No

Was the seat back adjustment altered by the accident? ☐ Yes ☐ No

Type of Restraints: _____

Did air bag deploy? ☐ Yes ☐ No If Yes, were you struck by airbag? ☐ Yes ☐ No Were you burned? ☐ Yes ☐ No

Body position: _____ Head position: ☐ Forward ☐ Left _____° ☐ Right _____° ☐ Up _____° ☐ Down _____°

Position of Hands: ☐ One on steering wheel ☐ Two on steering wheel ☐ N/A Were brakes applied at impact? ☐ Yes ☐ No

Dr. Initials: _____

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Patient: _____

Accident Description: (How did the accident happen?) _____

_____

_____

Were you aware of impending crash?: ☐ Yes ☐ No

Did your body hit any part of your vehicle? ☐ Yes ☐ No If yes, describe _____

Did anything inside the vehicle strike you? ☐ Yes ☐ No If yes, describe _____

Did your vehicle hit any other object after the crash? ☐ Yes ☐ No If yes, describe _____

Were you wearing a hat or eye or sunglasses? ☐Yes ☐ No If yes, were they still on after crash? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long _____

Estimated damage to your vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Estimated damage to other vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Since the crash, tell me **ALL** symptoms or injuries you have experienced and specifically when each began: _____

_____

_____

Where did you go after accident? ☐ Hospital ☐ Urgent Care ☐ Family Provider ☐ Home ☐ Work ☐ Other_____

Emergency Room Treatment:

Were you seen in the ER: ☐ Yes ☐ No Which hospital: _____ Were taken by ambulance? ☐ Yes ☐ No

Date seen if not taken by ambulance _____

Was treatment given? ☐ Yes ☐ No If yes, X-rays: ☐ Yes ☐ If yes, which body parts x-rayed _____

Results of X-rays: _____ Lab work ☐ Yes ☐ No Results: _____

Cervical collar ☐Yes ☐No Ice ☐ Yes ☐ No Medication: ☐ Yes ☐ No If yes, name of Rx: _____

Other treatment: _____ Follow-up Instructions: _____ ☐ None

Work restriction ☐ Yes ☐ No If yes, describe_____

Other Treatment Since accident #1:

Doctor: _____ Specialty: _____ Date first seen: _____

Referred by: _____ Treatment type: _____ Treatment frequency: _____

Treatment duration: _____ Currently treating? ☐ Yes ☐ No

Work restriction ☐ Yes ☐ No If yes, describe_____

Special tests: _____ Referred to: _____

Did treatment help? ☐ Yes ☐ No Comments: _____

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Patient: _____

Medications/Vitamins:
_____

Allergies:
_____
_____

Family History: #1.Father, #2.Mother, #3.Sister (A, B, Etc), #4.Brother (A, B, Etc.)

Cancer	Diabetes	Heart Disease	CVA
HBP	Epilepsy	TB	Other
Other	Other	Other	Other

Psycho-Social History:

Changes to Activities of Daily Living Since the Accident:
_____

_____
_____

Recreational/Exercise: Type: _____ Freq. ____/Wk; Duration _____ Min. / Hrs:
_____

Social Habits (Please Circle Appropriate Responses and Fill In The Blanks)

Tobacco: _____ Pack / ___Day, Week, for ___ Yrs; Chew _____ Yrs; Pipe _____ Yrs Caffeine (Soda, Coffee, Tea) _____/ Day

Alcohol _____ Glasses Of Wine, Beer, Mixed Drink/ Day, Wk, Mo.; Sleep Interrupted? ____ X's / Night For ____ Weeks Mo Yrs

Dr. initials: _____

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Patient: _____

Work Routine/Duties under Duress	Able		Restricted		Unable	Comments
Sit in office chair	1	2	3	4	5	
Stand erect	1	2	3	4	5	
Climb steps / stairs	1	2	3	4	5	
Stoop to retrieve	1	2	3	4	5	
Crouch to retrieve	1	2	3	4	5	
Kneel to retrieve	1	2	3	4	5	
Reach overhead	1	2	3	4	5	
Lift; waist to shoulder height	1	2	3	4	5	
Carry object, 100 feet	1	2	3	4	5	
Push	1	2	3	4	5	
Pull	1	2	3	4	5	
Balance	1	2	3	4	5	
Crawl	1	2	3	4	5	
Reach	1	2	3	4	5	
Handle objects appropriately	1	2	3	4	5	
Finger/Hand strength/coordination	1	2	3	4	5	

REVIEW OF SYSTEMS: *Please write all numbers that apply: #1. Presently have, #2. Previously had, #3. Related to crash*

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss
___Nervousness/depression
___Neuralgia
___Numbness
___Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction
___Near sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot Trouble
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

GENITO-URINARY
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

CARDIOVASCULAR
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

Other: _____

Dr. Signature: _____ Date _____

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PERSONAL AFFECTS QUESTIONNAIRE

We want to make sure and understand any of the personal consequences that this collision has caused you. Please complete and return to us at your convenience.

Patient Name: _____ Date: _____

Date of Injury: _____

The collision has affected me physically as follows (what are you no longer able to do or what increases pain, what was injured in the accident): _____

_____

_____

_____

_____

The collision has affected me emotionally as follows (have you been more frustrated, depressed, have you become emotionally withdrawn from family/friends): _____

_____

_____

_____

_____

The collision has affected me financially as follows (did you lose time from work, have you had to put out more money from your own pocket as a result of this accident, have you had to put out other expenses during this time you normally wouldn't): _____

_____

_____

_____

_____

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Patient Name: _____ Date: _____

The collision has affected my relationship with my family as follows (are you able to still do the same activities with family as before the accident? Have you been unable to perform certain physical activities with family since the accident? Has intimacy been hindered due to pain since the accident?): _____

_____

_____

_____

_____

The collision has affected me at work as follows (have you missed time from work? Are there certain work duties you cannot perform since the accident? Are there work duties that increase your pain?): _____

_____

_____

_____

_____

The collision has affected my home activities as follows (Are there chores you cannot due because of pain? What activities at home increase your pain?): _____

_____

_____

_____

_____

The collision has affected my hobbies as follows (Are you unable to enjoy previous activities due to pain? Has your social life been affected by the accident?): _____

_____

_____

_____

Patient Signature: _____ Date: _____

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For our file we would appreciate receiving a few items. Please make sure and bring with you the following items to your next appointment:

Patient Name: _____ Date of Injury: _____

If you do not have any of these items please circle n/a next to each you cannot provide either because they are not in existence or unavailable to you.

- Police report n/a
- Injury photos n/a
- Property damage photographs n/a
- Property damage estimates n/a
- Insurance declaration sheet n/a
- Health insurance card/booklet n/a
- Completed health history form n/a

_____ _____
Patient Signature Date

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Name: _____ Age: _____ Date of birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____ Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (_____)_____ Work Phone (_____) _____

Cell Phone (_____) _____ Email address: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify_____ **Relationship:** _____ **Phone (_____)** _____

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (_____) _____ Insured: _____

Claim #: _____ Policy #: _____

Claim Representative: _____

Telephone: (_____) _____ Fax: (_____) _____

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

Telephone: (_____) _____ Fax: (_____) _____

4) ATTORNEY: _____ Legal Assistant: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

HIPAA Compliance