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: ______________

Dr. Initials: ______________

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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: __________