REDDING SPORTS THERAPY & CHIROPRACTIC

OFFICE USE ONLY: S O A P

Full Name (Legal Name) _____ DOB _____ /_____ /_____Gender: M / F

AUTO ACCIDENT DETAILS

Date of the Accident_____ Time _____ AM / PM Was it reported to the police? Y / N

If yes, do you have a copy of the police report? Y / N If yes, please provide to the doctor. If no, please bring one in.

Were you the: DRIVER / FRONT SEAT PASSENGER / BACK SEAT PASSENGER of the vehicle?

Was a traffic violation issued to you? Y / N Was a traffic violation issued to the other party involved? Y / N / Unknown

What did your vehicle impact? ANOTHER VEHICLE / OTHER:_____

Please explain in detail how the accident occurred:_____

_____

If another vehicle, what was the make/model?_____

In which direction was the other vehicle headed? N / S / E / W Approx. speed of other vehicle: _____MPH

Location of accident (Street, Town):_____

List the # of passengers in your vehicle and which seats they occupied:_____

Were there other witnesses? Y / N Make/model of vehicle you were in:_____

In which direction were you headed? N / S / E / W Approx. speed of your vehicle at the time of collision: _____MPH

Did the impact to your vehicle come from the: FRONT / REAR / RIGHT / LEFT / OTHER: _____

During impact, were you facing: RIGHT / LEFT / FORWARD Were you: AWARE / SURPRISED by the impact?

Were you wearing a seat belt at the time of impact? Y / N If yes, was it a: SHOULDER HARNESS / LAP HARNESS

Was the vehicle equipped with air bags? Y / N If yes, did they deploy on impact? Y / N

Did any part of your body strike anything in the vehicle? Y / N If yes, describe what you hit and label the body part that hit:_____

In relation to the base of your skull, where was the headrest? ABOVE / BELOW / AT BASE

Did the accident render you unconscious? Y / N If yes, for how long?_____

Please list symptoms felt immediately after the accident:_____

Explain how you and your passengers got out of the vehicle: _____

Were you treated by emergency medical crews? Y / N If yes, explain:_____

Were you immediately transported to emergency care? Y / N If yes, by AMBULANCE / AIR CREW / PRIVATE VEHICLE

If transported, name the facility you were transported to:_____

MEDICAL TREATMENT after ACCIDENT

Name the emergency doctor(s) you have from the accident: _____

Name the follow up doctor(s) you have seen since the accident: _____

_____

Name of hospital and/or facilities since the accident: _____

_____

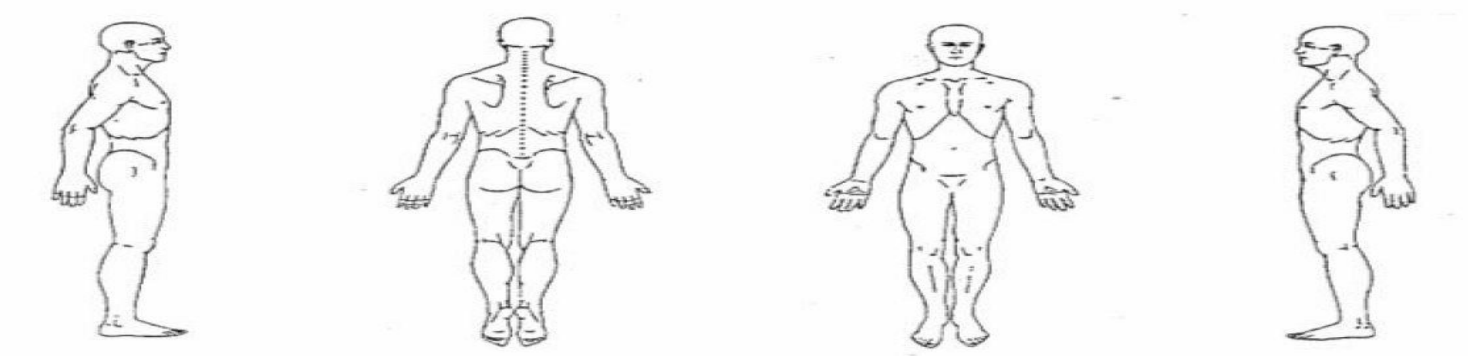
Please describe any treatment you received: _____

_____

_____

_____

CIRCLE all areas INJURED or AFFECTED by ACCIDENT



CURRENT SYMPTOMS ASSOCIATED with ACCIDENT

__abrupt vision change
__abrupt hearing loss
__arm/shoulder pain
__back pain
__back stiffness
__**bladder issues**
__**bowel issues**
__bleeding (internal)
__bruising
__buzzing/ringing in ear
__chest pain
__difficulty breathing
__difficulty sleeping
__difficulty swallowing
__dizziness
__fatigue
__fainting
__headaches
__hot flashes
__irritability
__jaw problems
__joint pain/swelling
__leg pain
__muscle weakness
__memory loss
__nausea
__neck pain
__neck stiffness
__night sweats
__numbness/tingling (hands/fingers)
__numbness/tingling (feet/toes)
__shortness of breath
__stomach upset
__tension
__weight loss/gain
__other_____
__other_____
__other_____

ACCIDENT DIAGNOSTIC TESTING

MRI / XRAY / CT / Diagnostic Ultrasound / Injections / Bone Density / Surgery (only include scan and tests from accident)

1 _____
TEST / SURGERY **FACILITY** **YEAR**

2 _____
TEST / SURGERY **FACILITY** **YEAR**

3 _____
TEST / SURGERY **FACILITY** **YEAR**

4 _____
TEST / SURGERY **FACILITY** **YEAR**

5 _____
TEST / SURGERY **FACILITY** **YEAR**

6 _____
TEST / SURGERY **FACILITY** **YEAR**

7 _____
TEST / SURGERY **FACILITY** **YEAR**

8 _____
TEST / SURGERY **FACILITY** **YEAR**

MEDICATIONS

Was medication prescribed? Y / N
If yes, please list all prescriptions:

_____
_____
_____
_____
_____
_____
_____
_____

NORMAL ACTIVITY RESTRICTIONS

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful. List "I" if the activity is physically impossible considering your injuries) in performing the following activities:

___Lying on Back ___Lying on Side ___Lying on stomach ___Sitting ___Standing ___Stretching ___Lovemaking ___Walking ___Running ___Sports ___Working ___Lifting ___Bending ___Kneeling ___Pulling ___Reaching ___Bathing

DAILY ROUTINE: Is your current condition affecting: WORK / SLEEP / DAILY routines? Y / N If yes, please explain:_____

_____

WORK ACTIVITY RESTRICTIONS

How many hours are in your normal workday?_____ Are your work activities restricted as a result of your injury? Y / N

If yes, please indicate your daily job duties restricted as a result of your injury:

STANDING / OPERATING EQUIPMENT / DRIVING / SITTING / TWISTING / WORK with ARMS ABOVE HEAD / WALKING / CRAWLING / TYPING / LIFTING / BENDING / STOOPING

Have you missed any work since the accident? Y / N If yes, indicate dates missed:_____

What positions can you work in with minimum physical effort, and for how long?_____

Can co-workers help you with heavy lifting? Y / N While in recovery, are there light duty tasks you could do? Y / N

SYMPTOMS PRIOR to the ACCIDENT (PRE-EXISTING)

Have you experienced similar symptoms prior to the accident? Y / N if yes, when:_____

_____

Has your condition __improved or __worsened or __stayed the same since your accident? Please explain:_____

_____

Did you have any diagnostic testing for these **pre-existing** conditions? Y / N if yes, what types of tests? MRI / CT / XRAY or OTHER (list):_____

PROVIDER USE ONLY

NOTES:_____

_____
_____
_____
_____
_____

VITALS:_____ **Today's Date** _____ /_____ /_____