



Sterling Rock Falls Clinic, Ltd.

A TRADITION OF EXCELLENCE IN THE SAUK VALLEY

I. PATIENT INFORMATION:

- A. Name _____
- B. Birth Date _____ Age _____
- C. Date of initial interview _____
- D. Date treatment started _____
- E. Was this patient treated by you before this accident?
Yes _____ No _____. If yes, state the date of your treatment: _____
- F. Has the patient seen any doctors for this accident?
Yes _____ No _____. If yes, what were their names, dates, and treatment? _____

- G. Has there been any significant trauma since this accident?
Yes _____ No _____. If yes, state the date, nature, and results of that trauma: _____

II. PATIENT HISTORY:

- A. ACCIDENT
- General Information
 - Date of Accident _____
 - Location _____
 - Type of Accident: Rr _____ Ft _____ Dr Side _____ Pass side _____ Ft Rt Ob _____
Ft Lt Ob _____ Rr Rt Ob _____ Rr Lt Ob _____
 - Road Conditions: Dry _____ Wet _____ Ice _____
 - Striking Vehicle:
 - Description _____
 - Speed _____
 - Damage _____
 - Struck Vehicle:
 - Description _____
 - Speed _____
 - Damage _____

6. Did an airbag employ? Yes _____ No _____
7. Patient Information at the Time of Impact:
- Was the patient surprised? Yes _____ No _____
 - Position in vehicle? Dr _____ Ft St Pass _____
 - What position was the patient's head?
Straight ahead _____ Up _____ degrees Down _____ degrees Rt _____ degrees Lt _____ degrees Combination _____
 - Headrest was _____ inches above, _____ inches below, the top of the patient's head.
 - Type of restraints? Shld/lap _____ lap _____ none _____
 - Seat angle? _____ degrees
 - What body part was hit by what car part?
Body part _____ Car part _____
 - Were there any broken bones? Yes _____ No _____
If yes, what body parts were broken? _____
 - Check the part of your body you received an injury or bruise as a result of a seat belt:
Stomach _____ Breast _____, No injury or bruise _____
 - Did you lose consciousness? Yes _____ No _____
 - Check the area you experienced:
Confusion _____ Nausea _____ Disorientation _____ Light Headed _____ Dizziness _____
Blurred Vision _____ Double Vision _____ Ringing or Buzzing in the ears _____
Epileptic Seizures _____
 - Are you currently suffering from any of the following (please check):
Restlessness _____ Difficult Concentrating _____ Sleeplessness _____ Difficult With
Memory _____ Forgetfulness _____ Trouble Parking The Car _____ Irritable _____
Trouble Controlling Emotions _____

B. POST ACCIDENT

- At The Scene Of The Accident:
Symptoms _____
Onset _____
Was the patient disorientated? Yes _____ No _____
- Leaving The Accident Scene:
 - Did the patient go to the hospital? Yes _____ No _____ If yes, check the mode of transportation: Ambulance _____ Patient's car _____ Driven _____ Taken by another because unable to drive _____
 - If went to the hospital, state which one and explain the length of stay _____

C. PRESENT HISTORY

- The symptoms that the patient had at the initial interview:
Symptoms _____ Onset _____

D. PRE-ACCIDENT

- Previous Automobile Accidents:
 - The patient has not been in a previous automobile accident _____

b. The patient has been in a previous automobile accident(s), and that information is on the "PREVIOUS ACCIDENT SHEET" _____

2. Previous Accidents Other Than Automobile:

a. The patient has not previously experienced any trauma significant to this accident _____

b. The patient has previously experienced the following trauma that is significant to this accident:

Trauma: _____

Significance: _____

Occurrence: _____

3. Patient's Health Condition Prior To Accident Significant To This Accident:

Condition: _____

Significance: _____

E. PROGNOSIS:

1. This patient's job description is as follows: _____

2. The injuries this patient has suffered will effect this patient's job description in the following way: _____

3. The injuries this patient has suffered in this accident will effect this patient's leisure time in the following way: _____

4. This accident has caused the following permanent damage: _____

5. Date of last treatment: _____

6. Date of release: _____

7. Percent of disability: _____

8. Approximate recovery to pre-accident status: _____ %

9. Cost of service rendered to patient by me: \$ _____

10. Cost of estimated service due to exacerbations: \$ _____

11. Referred to this doctor: _____

a. Reason _____

12. The time frame in which my treatment was given?
_____ to _____

13. Comments: _____