

# AUTO / WORK RELATED ACCIDENT

# 1

## ABOUT YOU

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_

# 2b

## WORK ACCIDENT

Date & Time of Accident \_\_\_\_\_ a.m. \_ p.m.

Was your accident directly related to your work? \_ Yes  \_ No

Briefly describe the events that occurred just before and during your accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Give the address where accident occurred: (if other than employer's address) \_\_\_\_\_  
\_\_\_\_\_

Was anyone else present during your accident? \_ Yes  \_ No

Did you report your accident to your employer? \_ Yes  \_ No

What recommendations did your employer make just after your accident? \_\_\_\_\_

Has this type of accident happened to you before? \_ Yes  \_ No

To the best of your knowledge, has this accident occurred in your workplace before? \_\_\_\_\_ \_ Yes  \_ No

In general:

Is your job physically stressful? \_\_\_\_\_ \_ Yes  \_ No

Is your job mentally stressful? \_\_\_\_\_ \_ Yes  \_ No

Is your workplace noisy? \_\_\_\_\_ \_ Yes  \_ No

Have you changed jobs in the last year? \_\_\_\_\_ \_ Yes  \_ No

# 2a

## AUTO ACCIDENT

Date & Time of Accident: \_\_\_\_\_ a.m. \_ p.m.

Were you the: \_ Driver \_ Front Passenger \_ Rear Passenger

If a traffic violation was issued, to whom was it issued? \_\_\_\_\_  
\_\_\_\_\_

Number of people in accident vehicle? \_\_\_\_\_

Did the police come to the accident site? \_\_\_\_\_ \_ Yes  \_ No

Was a police report filed? \_\_\_\_\_ \_ Yes  \_ No

Were there any witnesses? \_\_\_\_\_ \_ Yes  \_ No

Were you wearing your seat belt? \_\_\_\_\_ \_ Yes  \_ No

Was this vehicle equipped with airbags? \_\_\_\_\_ \_ Yes  \_ No

If yes, did it/they inflate? \_\_\_\_\_ \_ Yes  \_ No

In relation to the base of your skull, where was the headrest? \_\_\_\_\_ \_ Above \_ Below \_ At base of skull

What did your vehicle impact? \_ Another vehicle  \_ Other

If other, explain: \_\_\_\_\_

Did any part of your body strike anything in the vehicle? \_ Yes  \_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Make & model of the vehicle you were occupying? \_\_\_\_\_  
\_\_\_\_\_

Name of the location/street on which you were traveling? \_\_\_\_\_  
\_\_\_\_\_

In which direction were you headed?  N  S  E  W

What was the approx. speed of your vehicle? \_\_\_\_\_

Did the impact to your vehicle come from the:

\_ Front  \_ Rear  \_ Right Side  \_ Left Side  \_ Other

During impact, were you facing: \_ Right  \_ Left  \_ Forward

Were you \_ aware or \_ surprised by the impact?

If accident vehicle made impact with another vehicle...

Make and model of that other vehicle? \_\_\_\_\_  
\_\_\_\_\_

Direction other vehicle was headed? \_ N \_ S \_ E \_ W

Speed of the other vehicle? \_\_\_\_\_

In your words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Duluth MultiCare, Inc.**

3170 Peachtree Industrial Blvd. • Suite 170 • Duluth, GA 30097

Phone: 770-497-9700 • Fax: 770-497-0795

# 3

## AFTER INJURY

Did accident render you unconscious? .....  Yes  No

If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_  
\_\_\_\_\_

Have you gone to a Hospital or seen any other Doctor?  Yes  No

When did you go?  Just after accident  The next day  2 days plus

How did you get there?  Ambulance or  Private transportation

Name of Hospital and/or Attending doctor: \_\_\_\_\_  
\_\_\_\_\_

Was he/she a:  D.C.  M.D.  D.O.  D.D.S.

Describe any treatment you received: \_\_\_\_\_  
\_\_\_\_\_

Were X-rays taken? .....  Yes  No

Was medication prescribed? .....  Yes  No

Have you been able to work since this injury? .....  Yes  No

Are your work activities restricted as a result of this injury?  Yes  No

Indicate  the symptoms that are a result of this accident:

- Dizziness  Nausea  Difficulty sleeping  Chest pain
- Memory loss  Irritability  Arms/Shoulder pain  Back pain
- Headache(s)  Fatigue  Numb Hands/Fingers  Lower back pain
- Blurred vision  Tension  Jaw problems  Back stiffness
- Buzzing in ear  Neck pain  Shortness of breath  Leg pain
- Ears ringing  Neck stiff  Stomach upset  Numb Feet/Toes
- Other \_\_\_\_\_

Is your condition getting worse?

Yes  No  Constant  Comes & Goes

**Indicate your degree of comfort while performing the following activities:**

	Comfortable	Uncomfortable	Painful
	<small>EVEN IF ONLY SOMETIMES</small>		
Lying on back	_____	_____	_____
Lying on side	_____	_____	_____
Lying on stomach	_____	_____	_____
Sitting	_____	_____	_____
Standing	_____	_____	_____
Stretching	_____	_____	_____
Walking	_____	_____	_____
Running	_____	_____	_____
Sports	_____	_____	_____
Working	_____	_____	_____
Lifting	_____	_____	_____
Bending	_____	_____	_____
Kneeling	_____	_____	_____
Pulling	_____	_____	_____
Reaching	_____	_____	_____

**If any of your medical or account information has changed, please inform the doctor or other staff member.**

**Please remember you are ultimately responsible for your account.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

# 4

## RECOVERY

**To evaluate the effect that continuing work will have on your recovery please complete the following:**

How many hours are in your normal work day? \_\_\_\_\_

Please indicate  your daily job duties and any activities which you are occasionally asked to perform.

- Standing  Driving  Operating equipment
- Sitting  Twisting  Work with arms above head
- Walking  Crawling  Typing
- Lifting  Bending  Stooping
- Other \_\_\_\_\_

What positions can you work in with minimum physical effort and for how long? \_\_\_\_\_ N/A

Prior to the injury were you capable of working on an equal basis with others your age? .....  Yes  No  N/A

Do you work with others who can help you with any heavy lifting? .....  Yes  No  N/A

While in recovery, is there any light duty work you could request? .....  Yes  No  N/A

# 5

## ADDITIONAL INSURANCE

### 2nd Insurance Source or Auto Insurance

Type of Insurance: \_\_\_\_\_

Co.Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Insured's SS #: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

Agent's Name: \_\_\_\_\_

Have you retained an attorney:  Yes  No

If yes, whom: \_\_\_\_\_

His/Her Phone #: \_\_\_\_\_

I direct my attorney to pay any outstanding bills out of my settlement or I will be responsible for all treatment expenses incurred by this accident.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

## Duluth MultiCare, Inc.

3170 Peachtree Industrial Blvd. • Suite 170 • Duluth, GA 30097

Phone: 770-497-9700 • Fax: 770-497-0795

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

## ***Pain Intensity***

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

## ***Sleeping***

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

## ***Sitting***

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

## ***Standing***

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

## ***Walking***

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

## ***Personal Care***

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

## ***Lifting***

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓔ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

## ***Traveling***

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

## ***Social Life***

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

## ***Changing degree of pain***

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

Back  
Index  
Score

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

## ***Pain Intensity***

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much
- Ⓟ The pain comes and goes and is very severe.
- Ⓠ The pain is very severe and does not vary much.

## ***Sleeping***

- Ⓐ I have no trouble sleeping.
- Ⓛ My sleep is slightly disturbed (less than 1 hour sleepless).
- Ⓜ My sleep is mildly disturbed (1-2 hours sleepless).
- Ⓨ My sleep is moderately disturbed (2-3 hours sleepless).
- Ⓟ My sleep is greatly disturbed (3-5 hours sleepless).
- Ⓠ My sleep is completely disturbed (5-7 hours sleepless).

## ***Reading***

- Ⓐ I can read as much as I want with no neck pain.
- Ⓛ I can read as much as I want with slight neck pain.
- Ⓜ I can read as much as I want with moderate neck pain.
- Ⓨ I cannot read as much as I want because of moderate neck pain.
- Ⓟ I can hardly read at all because of severe neck pain.
- Ⓠ I cannot read at all because of neck pain.

## ***Concentration***

- Ⓐ I can concentrate fully when I want with no difficulty.
- Ⓛ I can concentrate fully when I want with slight difficulty.
- Ⓜ I have a fair degree of difficulty concentrating when I want.
- Ⓨ I have a lot of difficulty concentrating when I want.
- Ⓟ I have a great deal of difficulty concentrating when I want.
- Ⓠ I cannot concentrate at all.

## ***Work***

- Ⓐ I can do as much work as I want.
- Ⓛ I can only do my usual work but no more.
- Ⓜ I can only do most of my usual work but no more.
- Ⓨ I cannot do my usual work.
- Ⓟ I can hardly do any work at all.
- Ⓠ I cannot do any work at all.

## ***Personal Care***

- Ⓐ I can look after myself normally without causing extra pain.
- Ⓛ I can look after myself normally but it causes extra pain.
- Ⓜ It is painful to look after myself and I am slow and careful.
- Ⓨ I need some help but I manage most of my personal care.
- Ⓟ I need help every day in most aspects of self care.
- Ⓠ I do not get dressed, I wash with difficulty and stay in bed.

## ***Lifting***

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.
- Ⓠ I cannot lift or carry anything at all.

## ***Driving***

- Ⓐ I can drive my car without any neck pain.
- Ⓛ I can drive my car as long as I want with slight neck pain.
- Ⓜ I can drive my car as long as I want with moderate neck pain.
- Ⓨ I cannot drive my car as long as I want because of moderate neck pain.
- Ⓟ I can hardly drive at all because of severe neck pain.
- Ⓠ I cannot drive my car at all because of neck pain.

## ***Recreation***

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- Ⓛ I am able to engage in all my usual recreation activities with some neck pain.
- Ⓜ I am able to engage in most but not all my usual recreation activities because of neck pain.
- Ⓨ I am only able to engage in a few of my usual recreation activities because of neck pain.
- Ⓟ I can hardly do any recreation activities because of neck pain.
- Ⓠ I cannot do any recreation activities at all.

## ***Headaches***

- Ⓐ I have no headaches at all.
- Ⓛ I have slight headaches which come infrequently.
- Ⓜ I have moderate headaches which come infrequently.
- Ⓨ I have moderate headaches which come frequently.
- Ⓟ I have severe headaches which come frequently.
- Ⓠ I have headaches almost all the time.

Neck  
Index  
Score

# New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my health care, Duluth MultiCare originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Duluth MultiCare is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Duluth MultiCare reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Duluth MultiCare change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

\_\_\_\_\_  
Patient's Signature (authorized representative signing for the patient)

\_\_\_\_\_  
Date

## FOR OFFICE USE ONLY

Consent received by \_\_\_\_\_ on \_\_\_\_\_

Consent refused by patient, and treatment refused as permitted.

Consent added to the patient's medical record on \_\_\_\_\_

TPO CONSENT