MD PAIN
SPORT, SPINE, AND PAIN MANAGEMENT

Auto Accident Patient Paperwork

P: 303.750.8100 F: 303.369.1891

Save this form before entering any data to ensure your responses are not lost. Please print and sign your completed form prior to your appointment.

PATIENT INFORMATION

Patient Name: _____ Appointment Date: _____

Driver's License Number/State: _____ Social Security Number (last 4 #s): _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Home Address: _____ City/State/Zip: _____

Mailing Address different than Home Address: ☐ Yes ☐ No If yes, provide mailing address:

Mailing Address: _____ City/State/Zip: _____

Preferred Phone Number: _____ ☐ Home ☐ Mobile ☐ Work

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone: _____

Patient's Ethnicity: ☐ Native American ☐ Alaska Native ☐ African American/Black ☐ Asian/Pacific Islander ☐ Caucasian/White ☐ Hispanic/Latino ☐ non-Hispanic ☐ Other/Prefer not to answer

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

MOTOR VEHICLE ACCIDENT/PERSONAL INJURY CLAIM INFORMATION

Personal Injury Attorney's Name: _____

Personal Injury Attorney's Practice Name: _____

Telephone: _____ Email: _____

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Date of Accident: _____

Were you the? ☐ Driver ☐ Front passenger ☐ Rear passenger (left side) ☐ Rear passenger (right side)

Were you wearing a seat belt? ☐ Yes ☐ No

Make, model, and year of the vehicle you were occupying? _____

Make, model, and year of the other vehicle(s) involved? _____

Location where accident occurred? _____

Collision Type: ☐ Head-on ☐ Rear-end ☐ Broadside/T-bone ☐ Front impact (you hit the car in front of you)

Did the impact to your vehicle come from the? ☐ Front ☐ Rear ☐ Right ☐ Left ☐ Other _____

What did your vehicle impact? ☐ Another vehicle ☐ Nothing ☐ Other _____

Did airbags deploy? ☐ Yes ☐ No

If part of your body struck anything in the vehicle, *where?* ☐ Headrest ☐ Steering wheel ☐ Other _____

Did your head/neck whip in any of the following directions? ☐ Forward ☐ Backward ☐ Right ☐ Left ☐ None

Did you hit your head? ☐ If yes, *where?* _____ ☐ No *Did you lose consciousness?* ☐ Yes ☐ No

At the time of impact, what was the approximate speed of: *Your vehicle* _____ mph *The other vehicle* _____ mph

In your own words, please describe the accident in detail:

Was your vehicle drivable from the scene? ☐ Yes ☐ No

Did law enforcement/police come to the scene? ☐ Yes ☐ No

Did EMS/paramedics come to the scene? ☐ Yes ☐ No

If you answered yes to the previous question, *were you taken to the ER?* ☐ Yes ☐ No

If yes, where were you taken? _____

Please describe how you felt after the accident. When did your pain start? Where was your pain?

What were your symptoms? ☐ Dizziness ☐ Headaches ☐ Blurred Vision ☐ Hearing problems ☐ Nausea
☐ Memory Loss ☐ Fatigue ☐ Drowsiness ☐ Arm pain ☐ Shoulder pain ☐ Neck Pain ☐ Back Pain ☐ Back Stiffness
☐ Leg Pain ☐ Chest Pain ☐ Abdominal pain ☐ Numbness ☐ Other _____

Did you seek medical care? ☐ Yes ☐ No *If yes, when, and where?* _____

When did you seek care? ☐ Immediately after accident ☐ The next day ☐ Other _____

Were x-rays/MRIs/CTs done? ☐ Yes ☐ No *If yes, what was done?* _____

Was medication prescribed? ☐ Yes ☐ No *If yes, what kind/how often?* _____

Describe any other treatment you received: _____

Is your condition worsening? ☐ Yes ☐ No Where is your pain now? _____

Have you been able to work since the accident? ☐ Yes ☐ No Please describe any work/daily limitations:

Have you been in any other motor vehicle accidents? ☐ Yes ☐ No *If yes, when?* _____

If you answered yes to the previous question, did you have any pain from that accident or receive any medical treatment?

☐ Yes ☐ No *If yes, describe* _____

Prior to your most recent accident, did you have any history of your current pain complaints? ☐ Yes ☐ No

If yes, explain _____

Clinical Information

HAND DOMINANCE

☐ Right hand-dominant ☐ Left hand-dominant ☐ Ambidextrous Height: _____ Weight: _____ *lb.*

PLEASE INDICATE YOUR WORST PAIN OR CHIEF COMPLAINT (CHOOSE ONLY ONE)

☐ Headache	☐ Groin	☐ Anal/Rectal	☐ Left Shoulder
☐ Facial	☐ Neck	☐ Vaginal ☐ Scrotal	☐ Right Shoulder
☐ Chest Wall	☐ Mid Back	☐ Left Upper Extremity	☐ Left Hip
☐ Breast	☐ Low Back	☐ Right Upper Extremity	☐ Right Hip
☐ Abdominal	☐ Buttock	☐ Left Lower Extremity	☐ Left Knee
☐ Pelvic	☐ Tailbone	☐ Right Lower Extremity	☐ Right Knee

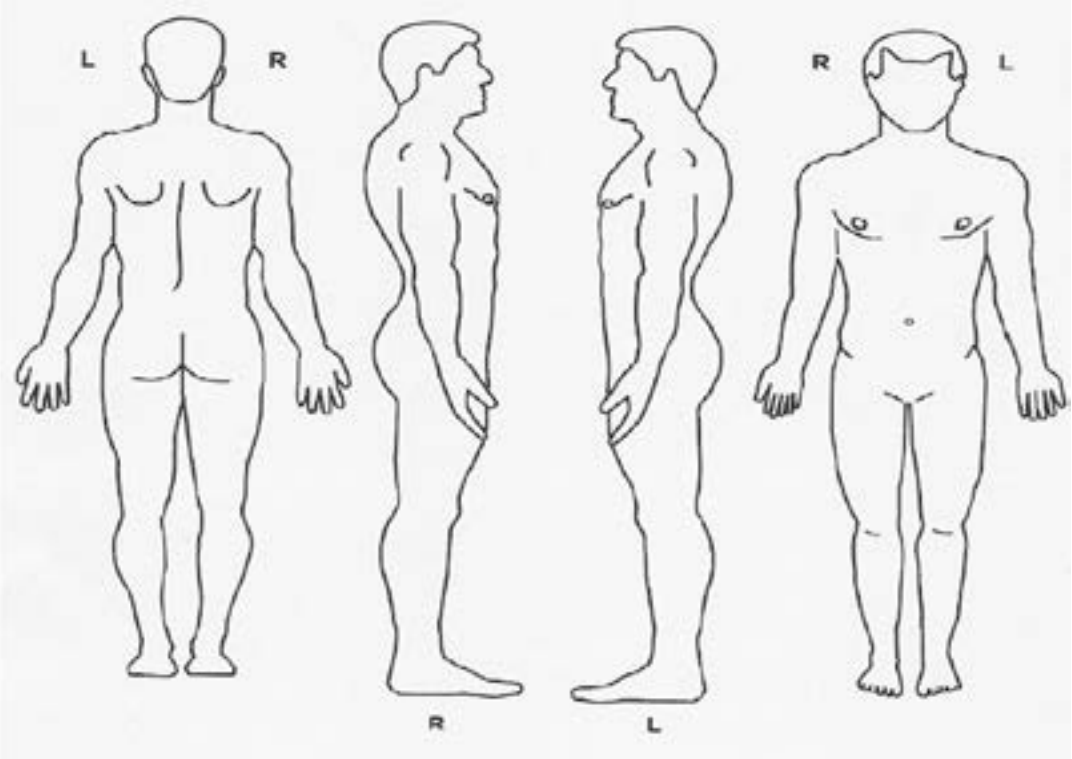
☐ Other: _____

PLEASE INDICATE ANY ADDITIONAL AREAS OF PAIN

☐ Headache	☐ Groin	☐ Anal/Rectal	☐ Left Shoulder
☐ Facial	☐ Neck	☐ Vaginal ☐ Scrotal	☐ Right Shoulder
☐ Chest Wall	☐ Mid Back	☐ Left Upper Extremity	☐ Left Hip
☐ Breast	☐ Low Back	☐ Right Upper Extremity	☐ Right Hip
☐ Abdominal	☐ Buttock	☐ Left Lower Extremity	☐ Left Knee
☐ Pelvic	☐ Tailbone	☐ Right Lower Extremity	☐ Right Knee

☐ Other: _____

Please describe your pain using the provided letters. Use the pictures below to mark the areas on your body where you feel the described sensations. Draw arrows indicating where the pain radiates.



Use the following letters to describe your pain.

Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T
Muscle Spasm = M

Please indicate if the following **INCREASE** or **DECREASE** your pain:

	INCREASE	DECREASE
Heat	☐	☐
Cold	☐	☐
Weather Changes	☐	☐
Standing	☐	☐
Walking	☐	☐
Exercise	☐	☐
Bending forward	☐	☐
Leaning back	☐	☐
Twisting at waist	☐	☐
Looking up	☐	☐
Leaning back	☐	☐
Turning head	☐	☐
Lying down	☐	☐
Lying on side (R/L)	☐	☐
Massage	☐	☐
Physical therapy	☐	☐
Bowel movement	☐	☐
Sneezing/Coughing	☐	☐
Stress	☐	☐
Medications	☐	☐
Other:		

Do you have any other symptoms associated with your pain?

☐ Sweating
☐ Skin color changes
☐ Swelling
☐ Hair/nail growth changes
☐ Skin temperature changes
☐ Bowel or bladder changes
☐ Dizziness
☐ Headaches
☐ Blurred vision
☐ Other _____

In the past 3 months have you developed any new symptoms?

☐ Balance problems
☐ Difficulty walking
☐ Bladder incontinence
☐ Bowel Incontinence
☐ Weakness; Where? _____
☐ Numbness; Where? _____
☐ Fine motor control problems (buttoning shirt, using a pencil, etc.)
☐ Falls/Near Falls; Date _____
☐ Use of assistive devices: ☐ Cane ☐ Walker ☐ Other _____
☐ Other symptoms (please explain) _____

PAIN SEVERITY, LOCATION, DESCRIPTION & OTHER FACTORS THAT AFFECT YOUR PAIN

How severe is your pain right now? _____ (0-10)

How severe is your worst pain (chief complaint) when aggravated? _____ (0-10)

What is an acceptable pain score goal for you to perform your daily activities? _____ (0-10)

Which activities are you no longer able to do because of your pain but *would like* to be able to do again?

PREVIOUS TREATMENTS

Mark any treatments received FOR THE PAIN YOU HAVE FROM THIS MOTOR VEHICLE ACCIDENT:

			IMPROVEMENT/EFFECT				
Treatment	**Body Part/Area/Level**	**Date(s)**	**Worse**	**None**	**Mild**	**Moderate**	**Excellent**
Chiropractic			☐	☐	☐	☐	☐
Acupuncture			☐	☐	☐	☐	☐
Massage Therapy			☐	☐	☐	☐	☐
Physical Therapy			☐	☐	☐	☐	☐
Aqua/Pool Therapy			☐	☐	☐	☐	☐
Weight Loss Program			☐	☐	☐	☐	☐
Neck/Back Brace			☐	☐	☐	☐	☐
TENS Unit			☐	☐	☐	☐	☐
Trigger Point Injection			☐	☐	☐	☐	☐
Epidural Steroid Injection			☐	☐	☐	☐	☐
Facet Injection			☐	☐	☐	☐	☐
Medial Branch Blocks			☐	☐	☐	☐	☐
Radiofrequency Ablation			☐	☐	☐	☐	☐
Sacroiliac Joint Injection			☐	☐	☐	☐	☐
Other Joint Injection			☐	☐	☐	☐	☐
Peripheral Nerve Block			☐	☐	☐	☐	☐
Sympathetic Nerve Block			☐	☐	☐	☐	☐
Spinal Cord Stimulator			☐	☐	☐	☐	☐
Intrathecal (Pain) Pump			☐	☐	☐	☐	☐
Ketamine Infusion			☐	☐	☐	☐	☐
Vertebroplasty			☐	☐	☐	☐	☐
Kyphoplasty			☐	☐	☐	☐	☐
Other Treatment:			☐	☐	☐	☐	☐

☐ I have not had any treatments for my current pain complaint(s).

DIAGNOSTIC TESTS AND IMAGING: LIST ANY TESTING/IMAGING DONE TO EVALUATE YOUR CURRENT PAIN COMPLAINT(S):

Test	**Body Part/Area**	**Date(s)**	**Facility**
X-ray			
CT Scan			
MRI			
EMG/NCV Study			
Discogram			

Other Treatment: _____

☐ I have not had any treatments for my current pain complaint(s).

Please list ALL CURRENT PAIN MEDICATIONS. Include all prescription and over-the-counter medications.

Medication Name	Dose (mg)	Frequency	Prescribing Provider	No Relief	Mild Relief	Moderate Relief	Excellent Relief
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

☐ I am currently not taking any pain medications.

If you are currently taking pain medications, **will the prescribing provider continue to prescribe these medications?** ☐ Yes ☐ No

Please list ALL NON-PAIN medications. Include prescription, over-the-counter medications, and herbal supplements.

Medication Name	Dose (mg)	Frequency	Medication Name	Dose (mg)	Frequency

BLOOD-THINNING MEDICATION

Please indicate which, if any, of the following BLOOD THINNING medications you are taking: (Mark ALL that apply)

☐ I am not CURRENTLY taking any blood thinners.

☐ Aspirin (☐ 81 mg ☐ 325 mg)	☐ Arixtra (fondaparinux)	☐ ReoPro (abciximab)	☐ Anti-inflammatories	☐ Garlic
☐ Pletal (cilostazol)	☐ Xarelto (rivaroxaban)	☐ Pradaxa (dabigatran)	☐ Heparin	☐ Ginseng
☐ Persantine (dipyridamole)	☐ Eliquis (apixaban)	☐ Plavix (clopidogrel)	☐ Lovenox (enoxaparin)	☐ Gingko
☐ Aggrenox (dipyridamole/aspirin)	☐ Savaysa (edoxaban)	☐ Effient (prasugrel)	☐ Coumadin (warfarin)	☐ Fish oil

Please list any other blood-thinning medications not listed above: _____

Name and phone number of prescribing physician: _____

ALLERGIES

Do you have any drug allergies? ☐ Yes ☐ No If 'Yes', please list all drugs and the allergic reactions:

Drug/Medication	Allergic Reaction

ANESTHESIA AND PAIN PROCEDURE HISTORY

Have you ever had any problems or adverse reaction to anesthesia? ☐ Yes ☐ No ☐ Never had anesthesia.

If 'Yes', which type of anesthesia? _____; what was the reaction? _____

Have you ever had an adverse reaction to the iodine contrast used during a pain procedure? ☐ Yes ☐ No

If 'Yes', what was the reaction? _____

MEDICAL HISTORY AND CONSENT FOR TREATMENT

I certify that the above information is accurate, complete, and true. I authorize MD Pain and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for MD Pain to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of MD Pain, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I authorize the MD Pain to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize MD Pain to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that MD Pain will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. In the event that I am asked to provide a urine, saliva and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine, saliva and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare, or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signature: _____ Date: _____

(Patient, guardian, or patient representative)

Printed name of person signing: _____