Auto Accident Questionnaire: (Patient needs to fill out this)

KOSA Acupuncture

531 E A St. Ste 100B, Jenks, OK 74037 **Fax: (800) 930-1401** **Phone: (918) 995-1100**

Name: First _____ Middle _____ Last _____
DOB: _____
Gender: ☐F / M☐
Address: _____ City _____ State Zip _____
Phone number: _____
Emergency contact: _____

****

Auto- insurance company (name, address and phone number)

_____
_____
_____

Auto insurance claim # and or policy number: _____
Adjuster's name: _____

Note to the patient: please inform your auto- insurance company that you are currently receiving treatments from this clinic.

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DOL (Date of loss) when: _____
Whose fault? _____
Belted driver? _____
Are there passengers? _____
What time: _____
What happened:

_____

_____

_____

_____

_____

Approximate speed: (you or other party):

_____

Did you go to the E.R?

If yes, what test were performed? (MRI, x-ray etc..) _____

_____

Immediately following the accident how did you feel? (Dizzy, headache, neck pain etc..)

_____

_____

_____

After one day or several days, how do you feel? (Worse, better, where specifically?) _____

_____

_____

_____

As of right now, list all your pains or symptoms due to the accident:

1) _____
Intensity of symptom: (mild, moderate, or severe?)
Duration of symptom: (constant, or sometimes)

2) _____
Intensity of symptom: (mild, moderate, or severe?)
Duration of symptom: (constant, or sometimes)

3) _____
Intensity of symptom: (mild, moderate, or severe?)
Duration of symptom: (constant, or sometimes)

4) _____
Intensity of symptom: (mild, moderate, or severe?)
Duration of symptom: (constant, or sometimes)

List any other current complaints due to the accident:

_____

_____

_____

Have you received other treatments for this accident?
If so please list: _____
Were the treatments effective?

_____

_____

Client's Name _____ **Date:** _____

Signature _____

For Doctor only

Objective:

ROM (Range of motion) of the _____
Flexion:_____
Extension:_____
Left turn:_____
Right turn:_____
Upon palpation of _____
Pt rated the pain a ___/10
ROM (Range of motion) of the _____
Flexion:_____
Extension:_____
Left turn:_____
Right turn:_____
Upon palpation of _____
Pt rated the pain a ___/10

Treatment goal:

_____

_____

_____

Treatment plan:
Patient needs to come to clinic _____x /week

Patient will receive: (circle)

Patient office visit 10min☐ 20mins☐ 30mins☐ 45mins☐ 1hours☐
Acupuncture 15mins☐ 30mins☐ 45 mins☐ >45 mins☐
Electrical Acupuncture 15mins☐ 30mins☐ 45 mins☐ >45 mins☐
Manual Therapy: (Guasha and/or Tuina,) 15mins☐ 30mins☐
Suction or Compression (Moxa and/or Cupping) 15mins☐ 30mins☐
Massage: 15mins☐ 30mins☐
Infrared Heat 15mins☐ 30mins☐
Electrical Stimulation 15mins☐ 30mins☐
Application of Hot or Cold Packs 15mins☐ 30mins☐

Special Instructions:

_____

_____

_____

Byoung Soon Kim _____ Date: _____