

**Auto Accident Questionnaire (Patient needs to fill out this)**  
**KOSA Acupuncture LLC**

531 E A St. Ste 100B, Jenks, OK 74037

Phone: (918) 995-1100

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

DOB: \_\_\_\_\_

Gender: F / M

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

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

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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:

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Approximate speed: (you or other party):

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Did you go to the E.R?

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

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

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

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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:

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Have you received other treatments for this accident?

If so please list: \_\_\_\_\_  
Were the treatments effective?

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**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: \_\_\_\_\_