Won S. Yoo, D.C.

Specializing in Spine & Joint Disorders · Injuries

Oakland Clinic — 281 13th Street, Oakland, CA 94612 — Tel. 510.465.8707 Fax. 510.465.8660
San Francisco Clinic — 1489 Webster Street, #202, San Francisco, CA 94115 — Tel. 415.931.3569 Fax. 415.931.3655
www.drwonyoo.com

PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM.
CLINIC LOCATION: ☐ **OAKLAND** ☐ **SAN FRANCISCO**

NAME: _____ HOME PHONE: ( ) _____-_____ WORK PHONE: ( ) _____-_____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
E-MAIL ADDRESS: _____@_____
SOCIAL SECURITY #: _____-_____-_____ BIRTH DATE: ___/___/_____ AGE: ___ SEX: ☐ MALE ☐ FEMALE
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED
YOUR INS. CO.: _____ POLICY#: _____
OCCUPATION: _____ EMPLOYER'S NAME & PHONE: _____
EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

NATURE OF ACCIDENT:

DATE OF ACCIDENT: _____/_____/_____ TIME OF DAY: _____:_____ ☐ AM ☐ PM
WERE YOU: ☐ DRIVER ☐ PASSENGER ☐ BACK-SEAT ☐ FRONT PASSENGER ☐ PEDESTRIAN
HOW MANY PEOPLE WERE IN THE VEHICLE (INCLUDING YOURSELF)? _____
WERE YOU WEARING SEAT BELTS? ◯ YES ◯ NO
IF YES, WHAT TYPE? ◯ FULL LAP & SHOULDER ◯ LAP
WERE YOU STRUCK FROM: ☐ FRONT ☐ BEHIND ☐ LEFT SIDE ☐ RIGHT SIDE
APPROXIMATE SPEED OF YOUR VEHICLE: _____MPH ☐ UNKNOWN
OTHER VEHICLE: _____MPH ☐ UNKNOWN
WHAT DIRECTIONS WERE YOU HEADED: ☐ NORTH ☐ SOUTH ☐ EAST ☐ WEST
ON (NAME OF STREET): _____
WHAT DIRECTION WAS OTHER VEHICLE HEADED: ☐ NORTH ☐ SOUTH ☐ EAST ☐ WEST
ON (NAME OF STREET): _____
PLEASE DESCRIBE HOW THE ACCIDENT HAPPENED: _____

_____

_____

DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE ACCIDENT? ◯ YES ◯ NO
IF YES, PLEASE DESCRIBE IN DETAIL: _____

_____

DO YOU HAVE ANY PAST OR CURRENT MEDICAL CONDITIONS THAT **NOT** RELATED TO THIS ACCIDENT?
◯ YES ◯ NO
IF YES, DESCRIBE IN DETAIL & TREATING DOCTOR IF APPLICABLE:

_____

_____

ARE YOU CURRENTLY UNDER CARE WITH ANY DOCTORS? ◯ YES ◯ NO
IF YES, PLEASE PROVIDE THE TREATING DOCTOR(S) & CONDITION: _____

PLEASE DESCRIBE HOW YOU FELT:

A) DURING THE ACCIDENT: _____
B) IMMEDIATELY AFTER THE ACCIDENT: _____
C) LATER THAT DAY: _____
D) THE NEXT DAY: _____

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Patient's Name: _____ **Date:** _____

- WHAT ARE YOUR **PRESENT COMPLAINTS AND SYMPTOMS**?

  _____

- WERE YOU UNCONSCIOUS IMMEDIATELY AFTER THE ACCIDENT? ◯ YES ◯ NO
  IF YES, HOW LONG?_____
- WHERE WERE YOU TAKEN AFTER THE ACCIDENT?
  ☐ HOSPITAL/EMERGENCY ☐ HOME ☐ FAMILY'S DOCTOR
- PLEASE LIST HOSPITAL & DOCTOR'S NAME(S):
  1. NAME: _____
     ADDRESS: _____
     PHONE #: _____
  2. NAME: _____
     ADDRESS: _____
     PHONE #: _____

  ADDITIONAL NAME(S) & CONTACT INFORMATION:_____
- WHAT TYPE OF TREATMENT DID YOU RECEIVE?:
  ☐ EXAMINATION ☐ X-RAY ☐ MEDICATION(S): _____
  ☐ LUMBAR BRACE ☐ CERVICAL COLLAR/BRACE ☐ SPLINT
- SINCE THIS INJURY OCCURRED, ARE YOUR SYMPTOMS:
  ◯ IMPROVING ◯ GETTING WORSE ◯ SAME

CHECK SYMPTOMS YOU NOTICED SINCE ACCIDENT:

☐ HEADACHE	☐ SHOULDERS (R /L)	☐ DIZZINESS	☐ STOMACH UPSET
☐ NECK PAIN/STIFF	☐ PINS & NEEDLES IN ARMS	☐ FATIGUE	☐ HEAD SEEMS TOO HEAVY
☐ SLEEPING PROBLEM	☐ PINS & NEEDLES IN LEGS	☐ DEPRESSION	☐ COLDSWEATS
☐ BACK PAIN	☐ NUMBNESS IN FINGERS	☐ FAINTING	☐ LOSS OF SMELL
☐ NERVOUSNESS	☐ SHORTNESS OF BREATH	☐ FEVER	☐ LOSS OF TASTE
☐ TENSION	☐ LIGHTS BOTHER EYES	☐ DIARRHEA	☐ FACE FLUSHED
☐ IRRITABILITY	☐ LOSS OF MEMORY	☐ FEET COLD	☐ BUZZING IN EARS
☐ CHEST PAIN	☐ LOSS OF BALANCE	☐ HANDS COLD	☐ OTHER _____

- SYMPTOMS OTHER THAN ABOVE: _____

- DO YOU HAVE ANY CONGENITAL (FROM BIRTH) FACTORS, WHICH RELATE TO THIS PROBLEM?
  ◯ YES ◯ NO
  IF YES, PLEASE DESCRIBE: _____
- HAVE YOU EVER BEEN INVOLVED IN AN ACCIDENT BEFORE? ◯ YES ◯ NO
  IF YES, PLEASE DESCRIBE, INCLUDING DATE, AS WELL AS INJURY(-IES):

  _____
- HAVE YOU LOST TIME FROM WORK BECAUSE of THIS ACCIDENT? ◯ YES ◯ NO
  IF YES, LAST DAY WORKED: _____
  TYPE OF EMPLOYMENT: _____
- OTHER PERTINENT INFORMATION: _____

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Patient's Name: _____ **Date:**_____

VISUAL ANALOG PAIN SEVERITY SCALE

Please Mark your pain level at the present time.

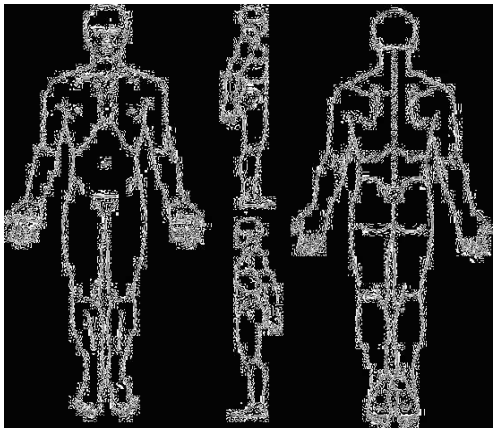
No Pain ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

Pain Level	Intensity Level	Disability	Restrictions
0	None	None	None
1	Minimal	Minimal handicap in the performance of any activity causing the pain. Able to perform all normal activities of daily living without significant pain. At the low end of "minimal," the pain is viewed as just an annoyance.	Can do all the normal activities without restriction, even though pain is present.
2 – 3	Slight	Slight handicap in the performance of any activity causing the pain. Able to perform all normal activities of daily living without significant pain. At the low end of "minimal," the pain is viewed as just an annoyance.	Can do all the normal activities without restriction, even though pain is present.
4 - 7	Moderate	There is marked handicap in the performance of any activity causing the pain. Some activities of daily living area typically performed more slowly, for a shorter duration, and/or there is the need for more frequent breaks. These activities may be minimized when possible so as to limit the pain.	Certain activities are difficult to perform and may require modifying the duration and intensity at which they are done.
8 - 10	Severe	Unable to do the activities that cause the pain. If the activity that causes the pain is attempted, flare-ups of the condition are likely. Avoidance of such activities is mandatory at this level of disability.	Major modifications in work and/or home activities are typically present.

Indicate the pain location and the type of pain that you are currently experiencing

Numbness	=====	Aching	aaaaa
Burning	xxxxx	Stabbing	/ / / / /
Pins and needles	ooooo	Other	_____



I certify that the above information is true and correct to the best of my knowledge.

Patient's Signature: _____ **Date:** _____