1381 E Osceola Pkwy, Kissimmee, FL 34744
Tel. (407) 906-1328 Fax. (407) 593-8452
Palmtreepain.com

Auto-PIP Assessment Form

Name: ____ Date:_____/_____/_____ DOB:_____/_____/_____

1. Location of injury-related pain? ____
2. Date of injury? ____
3. How did the accident happen? __Rear ended __T-boned __Head on collision Other please describe______________

4. *How soon after the accident did you develop symptoms?* ____

5. *Did any part of the body strike the inside of the vehicle (e.g, knee strike dashboard, head hit roof or headrest?* YES or NO *If yes, what part?* ____

6. *Was anyone else in the car?* YES or NO *If yes, were they hurt?* _________________________________

7. *Were you the driver?* YES or NO

   a. *If no, where were you sitting?* ____

8. *Were you wearing a seatbelt?* YES or NO *Did the airbag deploy?* YES or NO

9. *Did you lose consciousness?* YES or NO

10. *Were you able to exit from your car after the accident?* YES or NO

11. *Can you estimate how fast the vehicles were traveling?* YES or NO *If yes, how fast?* ________________

12. *Were you evaluated at a hospital after the accident?* YES or NO *If yes, how long?* ________________

13. Describe your pain (Circle all that apply):

    A spasm, aching, burning, burning, cold, cramping, dull, numb, pressure, sharp, shock-like, shooting, squeezing, stabbing, stinging, tenderness, tingling

14. Does the pain radiate anywhere? YES, NO If yes, where? ____

15. Please rate your pain on a scale of 1-10: Worst Pain? _____ Pain at its best? _____

16. *Do you have leg pain?* YES or NO *Low back pain?* YES or NO *Which is worst?* ___________________

17. *Do you have neck pain?* YES or *NO* *Arm pain?* YES or NO *Which is worst?* ___________________

18. *Do you have weakness in any arms or legs?* YES or NO *If yes, where?* ____________________________

19. When during the day do you have your pain? ____
20. What makes your pain better? ____
21. What makes your pain worse? ____
22. Have you received any medical care for your symptoms? YES NO

23. *If yes, what treatment(s)? Physical Therapy Chiropractic Pain Management*
24. *Describe your treatment(s).* ____
25. *Has there been any change in your symptoms? (new pain, less pain, increased pain)?* ________________
26. *Have any pains resolved?* ____
27. *Have you been treated by another physician for this injury?* _____________________________________
28. *Are you improved/same/worse?* ____
29. *Have you ever had neck or back surgery before? YES, NO If yes, what surgery?* ____________________

30. Are you taking any medication to help with the pain? YES, NO If yes, what medications? ________________
31. What NSAIDS are you taking? (Circle all that apply) Ibuprofen Naproxen Aspirin Meloxicam Diclofenac Tylenol
32. Have you had an MRI and/or X-RAYS? YES or NO If yes, when? ____________________________________
33. Have you had a previous work injury or motor vehicle accident? YES or NO
34. What was your functional status prior to the injury? ____
35. What was your functional status after the injury? ____
36. Do you have any constipation? YES, NO SOMETIMES

CURRENT MEDICATION LIST (please add dosages):

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MEDICAL HISTORY:

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ALLERGIES:

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SURGICAL HISTORY:

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FAMILY HISTORY:

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