Westcoast SpineCenter

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## Auto Accident Medical Profile

Today's Date________________________

Name(Last)____________________________(First)______________________________(M.I.)___________

Where did you feel pain?____________________________________________________________________

What are your symptoms?____________________________________________________________________

Name of any other Doctors consulted since your accident____________________________________________

________________________________________________________________________________________

Treatment received__________________________________________________________________________

How often did you receive care from other Doctors?_______________________________________________

Have you previously been injured in a similar manner?_____________________________________________

If so, explain_________________________________________________________________________________

Please list all hereditary/congenital medical conditions_____________________________________________

Please list all surgeries/operations and dates_____________________________________________________

Name of all medications and dosage you are currently taking _____________________________________

________________________________________________________________________________________

Do you smoke?__________________ Number per day_____________________________________________

Weekly alcohol consumption_______________________________ Daily water consumption_____________

Please explain in detail how your accident happened_______________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________