



**Dr. Nate Greenstein
Patient Accident Health History (1 of 3)**

Please complete all pages of the accident health history form. Be as complete and accurate as possible. If something does not apply, put N/A for not applicable. **Please print or type.**

Name: _____ Date: _____

Date of accident: _____ Time: _____ AM ; PM (circle one)

Location: _____

Type of accident: Auto On-The-Job Other (circle all appropriate responses)

If other, explain: _____

Have you lost any days of work? No Yes (circle one)

If yes, give dates: _____

If automobile accident, complete the following:

Were you: Driver Passenger Pedestrian (circle one)

Were you wearing a seat belt? Yes No (circle one)

Were you struck from: Behind Front Right side Left side (circle all appropriate responses)

Were traffic citations issued to you, the driver of your car and/or the driver of the other car? Yes No (circle one)

If yes, explain: _____

Explain in detail how the accident occurred. _____

If an on-the-job accident, complete the following:

Did you report the injury to your employer? Yes No (circle one)

Did your employer recommend you to Dr. Greenstein's office? Yes No (circle one)

Explain in detail how the accident occurred. _____

If not an automobile or on-the-job accident, complete the following:

Explain in detail how the accident occurred. _____

Were you hospitalized? No Yes (circle one)

If yes, explain: _____

List your current problems in order of their importance, describing each one in detail as to its location, nature and occurrence. _____

List any other problems you have experienced that are no longer present.



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List any problems you had before the accident and explain how this accident has affected them.

List all measures taken to-date to improve your problems including physicians seen, diagnostic tests performed, recommendations made and treatments rendered.

Explain how your injuries have changed (modified) your actions and the way you live.

List and give the dosage of all prescription and non-prescription medications you are currently taking, when you started them, the reason for them and the results.

List the nutritional supplements you are currently taking, including the brand name, content and potency. Indicate the frequency which they are taken.

Concerning your past history, list, briefly describe, and give the dates of any major past accident, injury, illness, sickness, surgery, and dental work.

Rate your current stress level on a scale of 1 to 10. (circle one number)

1 2 3 4 5 6 7 8 9 10
Extremely Mild Mild Moderate High Severe



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List the amount and type consumed or used for each of the following:

Water _____ Coffee _____ Tea _____
Soda _____ Alcohol _____ Tobacco _____

Are you on a special diet or have specific eating habits? [] No [] Yes

If yes, explain: _____

Are you on an exercise program? [] No [] Yes

If yes, explain: _____

Do you wear: Orthotics [] No [] Yes
Heel lift [] No [] Yes
Special shoes [] No [] Yes

How motivated are you in improving or overcoming your problems? (circle one number)

1 2 3 4 5 6 7 8 9 10
Not very Somewhat motivated Fairly motivated Very motivated Extremely motivated
motivated and expecting the Dr.
to do all the work Willing to accept responsibility for my own actions

What are your expectations with Dr. Greenstein?

What are your reservations with Dr. Greenstein?

Please read, sign and date the following:

I completed this health history to the best of my knowledge. It is considered up-to-date, factual and an accurate representation of my health. I will notify you of any future changes with my health history.

Patient/Legal Guardian: _____ Date: _____