VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name: ______________________________ Date: ____________

Date of Accident: ____________ Time of Accident: ____________

Please describe the accident in your words:

____

____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle? ____________

ACCIDENT SITE

Road/Street Name: ____________

City/State: ____________

Nearest intersection with road/street:

____

Driving conditions:

☐ Dry ☐ Wet ☐ Icy ☐ Other: ____________

Which direction were you headed ____________

Speed you were traveling: ____________

VEHICLE

Make and model of vehicle you were in:

____

Were you wearing a seatbelt? ☐ YES ☐ NO

If yes, what type? ☐ Lap ☐ Shoulder

Did the vehicle have airbags? ☐ YES ☐ NO

If yes, did they inflate properly? ☐ YES ☐ NO

Did your seat have a headrest? ☐ YES ☐ NO

If yes, what was the position of the headrest? ☐ Low ☐ Midposition ☐ High

OTHER VEHICLE

Make and model of other vehicle:

____

Which direction was the other vehicle headed?

____

Speed other vehicle was traveling: ____________

IMPACT

Did your car impact another vehicle? ☐ YES ☐ NO

Did your car impact a structure? ☐ YES ☐ NO

If yes, explain: ____________

Did any part of your body strike anything in the vehicle? ☐ YES ☐ NO

If yes, explain: ____________

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐Other ____________

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ YES ☐ NO

If no, which hand was on the wheel? ☐ RIGHT ☐ LEFT

Was your foot on the brake? ☐ YES ☐ NO

If yes, which foot was on the brake? ☐ RIGHT ☐ LEFT

Were you: ☐ Surprised by impact ☐ Braced for impact

POLICE

Did the police come to the accident site? ☐ YES ☐ NO

Were there any witnesses? ☐ YES ☐ NO

Was a police report filed? ☐ YES ☐ NO

Was a traffic violation issued? ☐ YES ☐ NO

If yes, to whom? ____________

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ YES ☐ NO If yes, for how long?___________

Please describe how you felt immediately after the accident:______________________________________

____

TREATMENT

Did you go to the hospital? ☐ YES ☐ NO

When did you go? ☐ Immediately after accident ☐ Next Day ☐ 2 days of more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital ______________________________ Name of doctor _______________________________

Diagnosis ____

Treatment Received ____

X-Rays taken ____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ___________ How many work days have you missed?_______

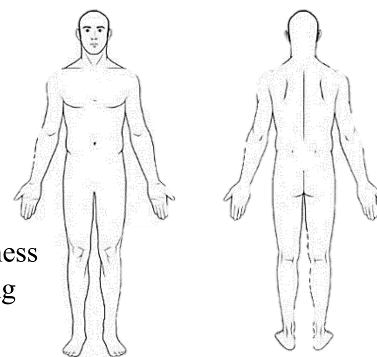
Prior to the injury were you able to work on an equal basis with others your age? ☐ YES ☐ NO

If you have had any of the following symptoms since your injury please check:

☐ Arm/Shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back Pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back Stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Tension
☐ Dizziness	☐ Jaw problems	☐ Vision Blurred
☐ Ear Buzzing	☐ Leg pain	
☐ Ear Ringing	☐ Memory loss	
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ YES ☐ NO

Mark an X on the picture where you continue to have pain →



Rate your pain on a scale of 1 (least) to 10 (severe):___________

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other

How often do you have the pain? ____

Is it constant or does it come and go? ____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Standing

☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health

____ ________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ________________

Please print the name of the Patient, Guardian or Personal Representative Date

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery
☐ Physical Therapy ☐ Chiropractic Services ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition:
____

Date of last:

Physical Exam: ________	Spinal X-Ray: ________
Blood Test: ________	Spinal Exam: ________
Chest X-Ray: ________	Urine Test: ________
Dental X-Ray: ________	MRI, CT scan, Bone scan ________

Place a mark to indicate if you have/ have had any of the following ☐Psychiatric Care

☐ AIDS/HIV	☐Chicken Pox	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Alcoholism	☐ Diabetes	☐ Liver Disease	☐ Rheumatic Fever
☐ Allergy Shots	☐ Emphysema	☐ Measles	☐ Scarlet Fever
☐ Anemia	☐ Epilepsy	☐ Migraine Headaches	☐ Stroke
☐ Anorexia	☐ Fractures	☐ Miscarriage	☐ Suicide Attempt
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Thyroid Problems
☐ Arthritis	☐ Goiter	☐ Multiple Sclerosis	☐ Tonsillitis
☐ Asthma	☐ Gonorrhea	☐ Mumps	☐ Tuberculosis
☐ Bleeding Disorder	☐ Gout	☐ Osteoporosis	☐ Tumors, Growths
☐ Breast Lump	☐ Heart Disease	☐ Pacemaker	☐ Typhoid Fever
☐ Bronchitis	☐ Hepatitis	☐ Parkinson's Disease	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Pinched Nerve	☐ Vaginal Infections
☐ Cancer	☐ Herniated Disk	☐ Pneumonia	☐ Venereal Disease
☐ Cataracts	☐ Herpes	☐ Polio	☐ Whooping Cough
☐ Chemical Dependency	☐High Cholesterol	☐Prostate Problem	☐ Other ________

Injuries/Surgeries you have had	Description	Date
Falls	________	________
Head Injuries	________	________
Broken Bones	________	________
Dislocations	________	________
Surgeries	________	________

Are you pregnant? ☐YES ☐ NO Due Date: ____________________

EXCERSISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking	Packs/Day ________
☐ Alcohol	Drinks/week ________
☐ Coffee/Caffeine Drinks	Cups/Day ________
☐ High Stress Level	Reason ________

MEDICATIONS

____
____

Pharmacy Name: ________
Pharmacy Phone: ________

ALLERGIES

____
____
____
____

VITAMINS/HERBS/ MINERALS

____
____
____