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"Life, Realigned!"

HISTORY OF AUTO ACCIDENT/SUBSEQUENT SYMPTOMS

History of Occurrence

Date of accident: _____ Time: _____am/pm Were you alone in car? □ yes □ no
□ Driver Passenger: □front right □front middle □rear right □rear middle □rear left
Driver of car: _____ Who owns the car? _____ Year and model of car: _____
Where was the accident? City: _____Street: _____ Cross Street: _____
Direction of travel: _____
Visibility at time of accident: □ Poor □ Fair □ Good
Road conditions at time of accident: □ Icy □ Rainy and wet □ Clear □ Dark □ wet/not raining
Your car: □ Hit another car □ Was hit….. in the … □ Right □ Left □ Rear □ Front □ Side
Type of accident: □ Head-on-collision □ Broadside collision □ Rear end collision
□ Front impact, rear-ended car in front
□ Non-collision (please describe)

_____

If other vehicles were involved, type of vehicle(s): _____
Describe and draw how the accident happened (note the car you were in as car "A")

_____

Did the police come to the accident scene? □ yes □ no
Did an ambulance come to the accident scene? □ yes □ no
Were you transported by ambulance to the hospital? □ yes □ no If yes, which hospital? _____
What was the approximate damage done to the car you were in? $_____ Was it drivable? □ yes □ no
How much damage was there to the other vehicle? _____ Was it drivable? □ yes □ no

Impact/Seat belt/Headrest/Speed

Seat belt use: Were you wearing a □ Lap belt □ Shoulder belt □ Both □ No belt worn
Were you pre-warned that the accident was about to happen? □ yes □ no
Did you brace for the impact? □ yes □ no

Does your car have headrests? □ yes □ no
If your car does have headrest, what was the position of those headrests compared to your head before the accident?

□ Top of headrest even with bottom of head □ Top of headrest even with top of head
□ Top of headrest even with middle of neck

Was your car braking? □ yes □ no Was your car moving at the time of the accident? □ yes □ no
If your car was moving, how fast would you estimate you were going? _____mph (estimate)
How fast was the other car traveling? _____ mph (estimate) □ Don't know

Head/Body position

Head/body position at time of impact: □ Head turned left □ Head turned right □ Head looking back
□ Head forward □ Body straight in sitting position
□ Body rotated left □ Body rotated right

Position of right and left arms at time of impact (ie: on steering wheel) _____
Position of right and left feet at time of impact (ie: on brake) _____
Did the impact cause your seat back to slip backward or break? □ yes □ no
Describe, in your own words, what happened to you upon impact: _____
_____
At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
_____
As a result of the accident, you were: □ Rendered unconscious □ Dazed, circumstances vague □ Shaken up but could function
Could you move all parts of your body? □ yes □ no
If no, what body parts could you not move, and why? _____
Were you able to get out of the car and walk unaided? □ yes □ no
Did you get any bleeding cuts or bruises? □ yes □ no
If yes, what bleeding cuts did you get from this accident? _____
If yes, what bruises did you get from this accident? _____
Please describe how you felt immediately after the accident (please be specific) _____
_____

Later that day/night_____ The following days _____

First Doctor/Hospital/Clinic Seen

Did you seek medical help immediately/soon after the accident? □ yes □ no
If yes, who did you first get treatment from? _____
Date of 1st visit: _____
Were you examined? □ yes □ no Were x-rays/MRI's taken? □ yes □ no
Were you given treatment? □ yes □ no If yes, what type of treatment? _____
Date of last treatment: _____

Second Doctor/Hospital/Clinic Seen

Name of Doctor/Hospital/Clinic seen: _____
Date of 1st visit: _____
Were you examined? □ yes □ no Were x-rays/MRI's taken? □ yes □ no
Were you given treatment? □ yes □ no If yes, what type of treatment? _____
Date of last treatment: _____

Third Doctor/Hospital/Clinic Seen

Name of Doctor/Hospital/Clinic seen: _____
Date of 1st visit: _____
Were you examined? □ yes □ no Were x-rays/MRI's taken? □ yes □ no
Were you given treatment? □ yes □ no If yes, what type of treatment? _____
Date of last treatment: _____

Activities of daily living

Do you notice any of your home activities (including domestic duties, social activities, hobbies, sports and recreation) that are different now than before the accident? □ yes □ no
If yes, list them as:
Those activities that you are unable to do (be specific): _____
Those activities that you are now limited due to pain (be specific): _____
Those activities that you are painful but not limited (be specific): _____
Those activities that are not as enjoyable (be specific): _____

Work status history

Have you missed time from work? □ yes If yes, full time off work: □ yes □ no Part time off work: □ yes □ no
□ no
□ Unable to work since the accident
□ I work under duress (work causes my symptoms to increase)

Has your injury increased the level of stress at work? □ yes □ no

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Symptoms since accident

□ Disturbed vision	□ Bowel Problems	□ Bladder problems	□ Nausea	□ Disturbed hearing
□ Dizziness	□ Anxiety	□ Depression	□ Breathing difficulty	□ Fatigue
□ Chest pain	□ Weight changes	□ Headaches	□ Nervousness	□ Weakness
□ Balance problems	□ Disturbed sleep	□ Racing heart	□ Decreased appetite	□ Exercise

Prior similar complaints

Did you have any physical complaints just before the accident? □ yes □ no
If yes, what physical symptoms did you have just before the accident? _____

Self/Home treatment that you have used

□ Rest	□ Immobilization	□ Medication	□ Home traction
□ Heating pad	□ Hot shower/bath	□ Cold/Ice	□ Bandages/Braces
□ Stretching	□ Exercise	□ Prayer	□ Meditation
□ Massage	□ Limited some activities		

If you did not seek medical or chiropractic care promptly, please explain why:

□ Was hoping pain/symptoms would go away in time
□ Tried self treatment
□ Was worried about the cost
□ Didn't know I could go to a chiropractor without a referral from medical doctor
□ Other: _____

_____

Thank You! In order for the doctor to provide the highest-quality and most-effective care we require as much information about your health condition/injury as possible.

Print Patient Name: _____ Signature: _____ Date: _____/_____/_____