Date: _____
Patient # _____

# Automobile Accident History

**Last** _____ **First** _____ **Middle Initial** _____ **Birth Date** _____ **Age** _____

**Address** _____ **City** _____ **ST**_____ **Zip** _____

**Phone (H)** _____ **(W)** _____ **(C)** _____

**Email** _____ **May we send you our online newsletter?** ☐yes ☐no

**Occupation** _____ **Employer** _____

**Spouse's Name** _____ **Business/Employer** _____ **Spouse Phone:** _____

**Who may we thank for referring you to our office?** _____ ☐Walk In ☐Advertisement ☐Promotion ☐Yellow Pages

**Who is your primary care physician?** _____ **Address:** _____

**Phone:** _____ **Date of last physical/exam?** _____ **With Whom?** _____

**Date of Accident:** _____ **Time of Accident:** _____ **am / pm** ☐Daylight ☐Dawn ☐Dusk ☐Dark

**Road conditions at the time of the accident:** ☐Wet ☐Dry ☐Snow ☐Ice ☐Other _____

**Was the accident on the job?** ☐yes ☐no **Where you in a company vehicle?** ☐yes ☐no **Where were you seated in the vehicle?**

☐Driver ☐Passenger ☐Rear-seat ☐Other _____

**Were you aware of the approaching collision prior to impact, or did it catch you by surprise?** ☐Aware ☐Surprise

**Did you lose consciousness upon impact?** ☐yes ☐no **Did you experience a flash of light or explosion in your head?** ☐yes ☐no

**Did the police come to the accident scene?** ☐yes ☐no **Is there a police report**☐yes ☐no

**Did you go to the hospital?** ☐yes ☐no **When?** ☐Immediately ☐___hours later ☐___days later **Which hospital?** _____

**How did you get to the hospital?** _____ **How long did you stay in the hospital?** _____

**What did the hospital do for your injuries?** (collars, splints, x-rays, medication etc.)_____

**What areas were x-rayed?** _____**What was their diagnosis?** _____

**What did they recommend for follow-up care?** _____

**Was any other doctor consulted after your accident?** ☐yes ☐no **If yes, please complete information below.**

**Dr.** _____ **Specialty?**_____ **Date first seen:**_____

**Type of treatment:**_____ **Treatment frequency:**_____ **How long did you treat?**_____

**Dr.** _____ **Specialty?**_____ **Date first seen:**_____

**Type of treatment:**_____ **Treatment frequency:**_____ **How long did you treat?**_____

**Were you wearing a seatbelt?** ☐yes ☐no **If yes, did you receive any injury or bruise from the seat belt?** ☐yes ☐no

**Did your head hit the head rest during the accident?** ☐yes ☐no **If adjustable, was the position of the head rest altered?** ☐yes ☐no

**Was the seat adjustment altered by the accident?** ☐yes ☐no **Was the seat broken by the accident?** ☐yes ☐no

**Did the air-bag deploy?** ☐yes ☐no **If yes, did it strike you?** ☐yes ☐no **If yes, where?** _____

**Which way was your head pointing at the point of impact?** ☐Straight ☐Right ☐Left **Body?** ☐Straight ☐Right ☐Left

**Where were your hands?** ☐One on the wheel ☐Both on the wheel ☐Not Applicable

**Were you wearing a hat or glasses at the time of impact?** ☐yes ☐no **If so, were they still on after the accident?** ☐yes ☐no

## YOUR CAR

**List the year, make and model of the car you were in:** YEAR: _____ MAKE: _____ MODEL: _____

**Was your car stopped at the time of impact?** ☐yes ☐no If yes, was the driver's foot on the brake? ☐yes ☐no If no, estimate the speed of the vehicle you were in: _____mph

**If your vehicle was moving at the time of impact, was it:** ☐Slowing down ☐Gaining speed ☐Steady speed

## THE OTHER CAR

**List the year, make and model of the other car :** YEAR: _____ MAKE: _____ MODEL: _____

**Was the other car moving at the time of impact?** ☐yes ☐no If yes, what was the approximate speed of the vehicle : _____mph

**At the time of impact, was the other car:** ☐Slowing down ☐Gaining speed ☐Steady speed

***Please describe, to the best of your knowledge, what happened during this accident.***

_____

_____

_____

_____

_____

_____

You may draw the accident here

## AUTOMOBILE INSURANCE INFORMATION

**Driver of the automobile you were in:** _____ **Name of their auto insurance:** _____

**Policy #:** _____ **Claim #:** _____

**Auto insurance phone #:** _____ **Name of insurance adjuster:** _____

**Driver of the other vehicle:** _____ **Name of their auto insurance:** _____

**Policy #:** _____ **Claim#:** _____

**Auto insurance phone #:** _____ **Name of insurance adjuster:** _____

**Have you retained an attorney?** ☐yes ☐no **Name:** _____ **Phone #:**_____

**At the time of the accident, did you become or experience any of the following?** ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: _____

**Do you still have any of those symptoms?** ☐yes ☐no **If yes, which ones?** _____

**Check symptoms you have noticed since the accident.**

| | | | | |
|---|---|---|---|---|
| ☐ Headaches/Migraines | ☐ Neck Pain | ☐ Upper Back Pain | ☐ Shoulder Pain | ☐ Midback Pain |
| ☐ Low Back Pain | ☐ Depression | ☐ Buzzing In Ears | ☐ Arm/Leg Pain | ☐ Jaw Pain/Clicking |
| ☐ Dizziness | ☐ Fatigue | ☐ Loss of Memory | ☐ Cold Hands/Feet | ☐ Numbness/Tingling |
| ☐ Loss of Smell | ☐ Irritability | ☐ Digestive Problems | ☐ Joint Pain/Stiffness | ☐ Menstrual Problems |
| ☐ Pinched Nerve | ☐ Loss of Sleep | ☐ Loss of Balance | ☐ Chest Pain | ☐ Light Bothers Eyes |
| ☐ Fever | ☐ Nervousness | ☐ Vision Problems | ☐ Urinary Problems | ☐ Sleeping Problems |
| ☐ Paralysis | ☐ Tension | ☐ Fainting | ☐ Pins/Needles Feeling | ☐ Stomach Upset |
| ☐ Difficulty Swallowing | ☐ Sciatica | ☐ Sinus Pain | ☐ Sore Muscles | ☐ Head Feels To Heavy |
| ☐ Other: | | | | |

**CURRENT COMPLAINTS -List current symptoms separately in order of severity.**

**1* Body Part:**_____

**Date symptom first appeared:** _____

**How often do you experience these symptoms?** ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

**What makes symptom increase?** _____

**What makes symptom decrease?**_____

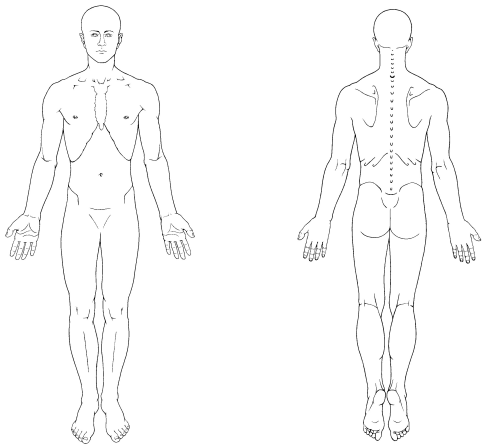
**Type of pain?** ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

**Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)**

**0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10**

**Where does pain radiate to?** _____

**Please mark areas of pain on the figures below**



**2* Body Part:** _____

**Date symptom first appeared:** _____

**How often do you experience these symptoms?** ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

**What makes symptom increase?** _____

**What makes symptom decrease?**_____

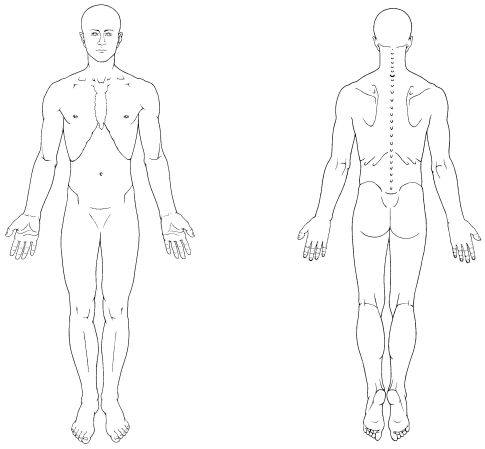
**Type of pain?** ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

**Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)**

**0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10**

**Where does pain radiate to?** _____

**Please mark areas of pain on the figures below**



**3* Body Part:** _____

**Date symptom first appeared:** _____

**How often do you experience these symptoms?** ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

**What makes symptom increase?** _____

**What makes symptom decrease?**_____

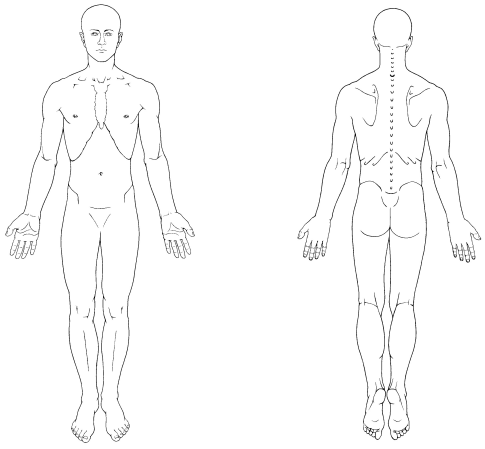
**Type of pain?** ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

**Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)**

**0 ◊◊◊ 1 ◊◊◊ 2 ◊◊◊ 3 ◊◊◊ 4 ◊◊◊ 5 ◊◊◊ 6 ◊◊◊ 7 ◊◊◊ 8 ◊◊◊ 9 ◊◊◊ 10**

**Where does pain radiate to?** _____

**Please mark areas of pain on the figures below**



## OCCUPATIONAL INFORMATION

**Job involves:** ☐Sitting ☐Standing **How long?** _____ ☐Lifting **How much?** _____ ☐Bending ☐Twisting ☐Turning ☐Stooping

**Physical activity at work:** ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

**Have you missed any time from work due to the accident?** ☐yes ☐no **If yes, how many days?** _____ **Dates:** _____

**Are your work activities restricted as a result of this accident?** ☐yes ☐no **If yes, please explain.**_____

**Do any of your work activities aggravate your present main complaints?** ☐yes ☐no **If yes, please explain.** _____

_____

**Do you smoke?** ☐yes ☐no If yes, how many packs per week?_____**Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____

**Do you consume alcohol?** ☐yes ☐no If yes, how many drinks per week? _____

**Do you consume caffeine?** ☐yes ☐no If yes, how many drinks per day? _____

**Do you exercise?** ☐yes ☐no If yes, how many times per week and what type? _____

**Do you have a high stress level?** ☐yes ☐no If yes, list reasons:_____

**Please list any medications or vitamins you are currently taking (including dosage).**

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

## X-RAY CONFIRMATION - FEMALES

**At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.**

_____ _____

**Patient Signature** **Date**

**I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.**

_____ _____

**Patient Signature** **Date**

## AUTHORIZATION FOR CARE OF MINOR

**CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at *Discover Chiropractic & Rehabilitation* and whom ever they designate as assistants to administer care to child.**

**Name of Child / Minor (please print)**_____

**Name of Parent / Guardian (please print)** _____

**Parent / Guardian signature:** _____ **Date:** _____