CHIROPRACTIC SPORTS & WELLNESS PC AUTO ACCIDENT HISTORY

WELCOME. The doctor and staff of ***Chiropractic Sports & Wellness PC*** welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care; a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS. Please complete questions 1 through 67 to the best of your ability. Be as descriptive as possible and check all descriptors that apply. This form was designed to reduce the time involved in taking your initial history. In doing so, we are able to spend more time on determining the nature of your current problem through examination procedures. If you have questions, please ask a staff member for assistance or clarification. Please inform the doctor if there are circumstances surrounding your accident that are not covered here and that you feel would be helpful.

Name ____ Today's Date ______/______/______

HISTORY OF OCCURRENCE

Date of the Accident ______/______/______

1. I was the/a: ☐ Pedestrian ☐ Driver ☐ Passenger- Left Front ☐ Passenger- Left Rear ☐ Passenger- Right Front ☐ Passenger- Right Rear ☐ Passenger- Center Front ☐ Passenger- Center Rear

   a. What was your point of impact? ☐ Head-On ☐ Rear-End ☐ Left Front ☐ Left Rear ☐ Right Front ☐ Right Rear

   b. Did you feel pain immediately following the accident? ☐ Yes ☐ No

   If you answered no, how long after the accident was it before the pain started? ☐ 30min-1hr ☐ 1-4 hours ☐ 4 -12 hours ☐ 12 -24 hours ☐ _____ Days

   c. Where did you go after the accident? ☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor

   d. Did you receive any of the following: ☐ X-ray ☐ CT Scan ☐ MRI ☐ Lab work ☐ Treatments/Medications

   e. How did you get there? ? ☐ Drove self ☐ Somebody Else ☐ Ambulance ☐ Police ☐ Other: ___________

   f. List any doctors you've seen prior to this first visit to our office, their specialty, and any treatments received:
   ____

2. Patient Vehicle Type *(What type of car were you driving?)*
☐ Compact ☐ Mid-size ☐ Full-size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other ___________

3. Second Vehicle Type *(What was the opposing car type?)*
☐ Compact ☐ Mid-size ☐ Full-size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other ___________

4. Third Vehicle Type:
☐ Compact ☐ Mid-size ☐ Full-size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other ___________

5. Road Conditions: ☐ Dry ☐ Icy ☐ Wet ☐ Clear ☐ Foggy ☐ Dark ☐ Other ___________

6. Road Type: ☐ Concrete ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other _________________________________

7. Were you aware the accident was going to occur? ☐ Yes ☐ No

8. Were you wearing a seatbelt? ☐ Yes ☐ No

9. Did your airbag deploy? ☐ Yes ☐ No

10. Does your car have a headrest? ☐ Yes ☐ No

11. What position was the headrest in? ☐ Up ☐ Down ☐ Middle

12. Head Position: *(At the time of the accident were you looking...)* ☐ Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down ☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

13. Were you pushing the brake (stopping) either during or before impact? ☐ Yes ☐ No

14. Was your car moving before impact? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

15. Was the driver of the second vehicle braking (stopping)? ☐ Yes ☐ No

16. Was the second vehicle moving before impact? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

17. Was the driver of the third vehicle braking (stopping)? ☐ Yes ☐ No

18. Was the third vehicle moving before impact? ☐ Yes ☐ No
If yes, how fast? (mph.) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

COLLISION DETAILS *(Describe how the cars collided. My vehicle was...)*

19. First Impact: ☐ Hit By Another Vehicle ☐ Hit Another Vehicle ☐ Hit By An Object ☐ Hit An Object

(My car was hit in the...) ☐ Front ☐ Front-Right ☐ Front-Left ☐ Left ☐ Right ☐ Right-Rear ☐ Left-Rear ☐ Rear ☐ Top

20. Second Impact ☐ Hit By Another Vehicle ☐ Hit Another Vehicle ☐ Hit By An Object ☐ Hit An Object

(My car was hit in the...) ☐ Front ☐ Front-Right ☐ Front-Left ☐ Left ☐ Right ☐ Right-Rear ☐ Left-Rear ☐ Rear ☐ Top

COLLISION RESULTS *("During the accident my...")*

21. Body was thrown: ☐ Backward ☐ Forward ☐ Left

22. Head Hit: ☐ Airbag ☐ Another Person's Body ☐ Back Of Front Seat ☐ Dashboard ☐ Front Windshield ☐ Rear-View Mirror ☐ Side Window/Door ☐ Steering Wheel ☐ Windshield

23. Chest Hit: ☐ Another Person's Body ☐ Back Of Front Seat ☐ Dashboard ☐ Side Window/Door ☐ Steering Wheel

24. Shoulders Hit: ☐ Another Person's Body ☐ Back Of Front Seat ☐ Shoulder Harness ☐ Side Window/Door

25. Knees Hit: ☐ Another Person's Body ☐ Back Of Front Seat ☐ Center Console ☐ Dashboard ☐ Door Panel ☐ Steering Wheel

26. Hips Hit: ☐ Another Person's Body ☐ Back Of Front Seat ☐ Center Console ☐ Dashboard ☐ Door Panel ☐ Steering Wheel

If other area then describe:____

VEHICLE DAMAGE

27. First Vehicle: ☐ Totaled ☐ Significant Damage ☐ Light Damage ☐ No damage
28. Second Vehicle: ☐ Totaled ☐ Significant Damage ☐ Light Damage ☐ No damage
29. Third Vehicle: ☐ Totaled ☐ Significant Damage ☐ Light Damage ☐ No damage

30. Were you hospitalized? ☐ Yes ☐ No *(If yes, please answer the questions in the paragraph below.)*

When were you hospitalized? ☐ Date ____/_____/______

☐ Immediately ☐ Later The Same Day ☐ The Next Day.

⇨How were you transported to the hospital? ☐ Ambulance ☐ Life Flight ☐ Private Transportation

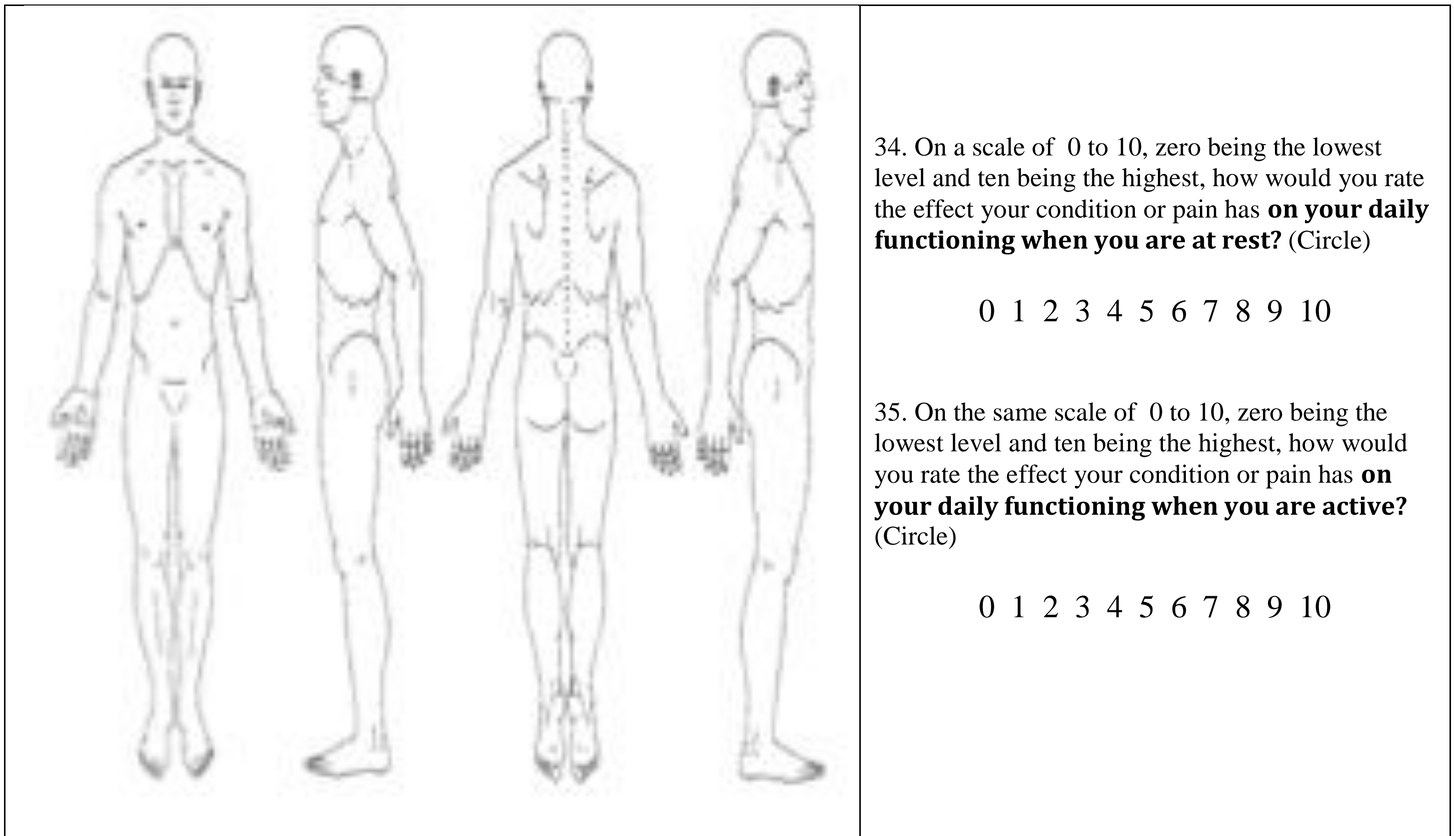
⇨What did the hospital recommend? ☐ No Instructions ☐ See This Clinic ☐ See DC
☐ See Own Doctor ☐ See Neurologist ☐ See Orthopedist ☐ Over The Counter Medication
☐ Prescription Medication ☐ Other ___________________________

⇨Did you have any x-rays, CT Scans or MRI's taken? ☐ Yes ☐ No If yes, what areas? ________________
____

31. How would you describe your current symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness ☐ Other_____________

32. Describe the quality of your symptoms: ☐ Burning Pain ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness
☐ Tingling ☐ Other ____

33. Please mark the area of your symptoms:



34. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your condition or pain has **on your daily functioning when you are at rest?** (Circle)

0 1 2 3 4 5 6 7 8 9 10

35. On the same scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your condition or pain has **on your daily functioning when you are active?** (Circle)

0 1 2 3 4 5 6 7 8 9 10

36. When did this condition originally begin, if present before the accident? ____

37. Is your condition currently... ☐ Worsening ☐ Improving ☐ Unchanged ?

38. If you condition has worsened or is worsening, when did the increased symptoms start? ____________________

39. When was the last time you experienced these symptoms? _______________________________________

40. Is your condition worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity
AND is it mostly: ☐ Intermittent ☐ Constant throughout the day

41. Is your condition better in: ☐ Warm Temp ☐ Cold Temp ☐ Neither ☐ Unknown

42. Is your condition worse in: ☐ Warm Temp ☐ Cold Temp ☐ Damp ☐ None ☐ Unknown

43. Check any of the following signs or symptoms that are associated with your current condition:

☐ Headaches (Describe your headaches in detail): ____

____

☐ Blurred Vision ☐ Depression ☐ Dizziness ☐ Irritability / Mood Swing ☐ Ringing in the ears
☐ Fainting ☐ Confusion ☐ Loss of Concentration ☐ Loss of Smell ☐ Localized Tingling
☐ Nausea ☐ Ringing in the Ears ☐ Stiffness ☐ Problems Sleeping
☐ Radiating Pain/Sensation (Describe the location and type of sensation): ____________________________

____

☐ Weakness (Describe the location): ____

____

☐ Aches ☐ Cold Limbs ☐ Dizziness ☐ Bruising ☐ Fatigue ☐ Fever ☐ Heartburn
☐ Muscle Spasms ☐ Nausea ☐ Numbness ☐ Pale Bluish Skin ☐ Panic ☐ Pins & Needles
☐ Runny Nose ☐ Short Breath ☐ Stiffness ☐ Sweating ☐ Swelling ☐ Tingling ☐ Vomiting
☐ Others Not Listed ____

44. Do your symptoms seem to be better with:
☐ Nothing ☐ Activity ☐ Bending ☐ Cold
☐ Heat ☐ Massage ☐ Movement
☐ Over-The-Counter Medications ☐ Prescription Medications
☐ Rest ☐ Stretching ☐ Sitting ☐ Standing ☐ Twisting
☐ Walking ☐ Other ____________________________________

PATIENT AUTO ACCIDENT INFORMATION SHEET

INSTRUCTIONS: The following information is needed upon your arrival here at CHIROPRACTIC SPORTS & WELLNESS PC. Please take this time to complete the appropriate information below as it relates to your injury. This information is used for billing purposes only. If you do not have this information available at this time, please let a staff member know. You will be required to have the information completed and returned upon you next visit.

Patient Name: ____

Date of Accident/Injury/Loss: ____

AUTO ACCIDENT INSURANCE INFORMATION

If you have not completed an application of benefits from you auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier: ____

Auto Insurance Carrier Phone #: ____ Ext. ______________

Insurance Carrier Address: ____

____

Claim Adjuster's Name: ____

Claim Number: ____