Motor Vehicle Accident History

(Please Print)

Patient Information **Acct#**

Dr./Mr./Mrs./Ms./Miss *(circle one)* Marital status *(circle one)* M S W D

Last Name First Name Middle Initial Nick Name

Address City State Zip Code

Home phone#_____ Pager#_____ Cell Phone#_____

Email address_____

Social Security No._____ Date of Birth_____ Sex [ ] M [ ] F

Occupation _____ Employer_____

Work Address_____ Work Phone#_____

Person to contact in an emergency_____ Phone#_____

Responsible Party

Name of person responsible for payment of this account _____

Relationship to patient_____ Phone#_____

Address City State Zip Code

Insurance Information

If you have any insurance information please give it to the staff person assisting you.

Accident/Injury History

1. Date of Accident:_____ Time of Day:_____ Road Condition: ( ) Dry ( ) Wet
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle?_____
4. Were you wearing a seat belt? ( ) Y ( ) N If no, go to question #6
5. If yes, were you wearing a lap belt? ( ) Y ( ) N Lap belt and shoulder harness? ( ) Y ( ) N
6. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
   On (name of street and city):_____
7. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
   On (name of street and city):_____
8. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
   Other combination, please describe:_____
9. What was the position of your head during the accident?
   ( ) Straight Ahead ( ) Turned Right ( ) Turned Left ( ) Other _____

10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard,etc)?

( ) Y ( ) N

If yes, please explain:_____

11. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)?

( ) Y ( ) N

If yes, please describe:_____

12. Approximate speed of your car:_____ mph Estimated speed of the other car:_____ mph

13. Make/model of your car:_____ Make/model of the other vehicle:_____

14. Were the police notified? ( ) Y ( ) N ***Please provide this office with a copy of the police report.***

15. In your own words, please describe the accident:_____

_____

_____

16. Did you have any physical complaints BEFORE the accident? ( ) Y ( ) N

If yes, please describe in detail:_____

_____

17. Please describe how you felt:

a. DURING the accident:_____

b. IMMEDIATELY AFTER the accident:_____

c. LATER THAT DAY:_____

d. THE NEXT DAY:_____

18. Were you knocked unconscious? ( ) Y ( ) N If yes, for how long?_____

19. Where were you taken after the accident?_____

20. Have you been treated by another doctor since this accident? ( ) Y ( ) N

If yes, please list the doctor's name and address:_____

_____

What type of treatment did you receive?_____

_____

21. Did this accident occur while you were performing your regular job duties? ( ) Y ( ) N

22. How do you feel now, what is your **number one** problem or the **one area** of greatest pain?

_____

23. Please rate the level of this pain on the following scale: **0 is no pain, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**

24. Since this injury occurred, is your pain: ( ) Improving ( ) Getting Worse ( ) Staying the Same

25. How often do you experience the pain?

___ 1-2 hours per day ___ About half of the day

___ Most of the day ___ The pain never goes away

26. How does the pain affect your daily activities?

___ It does not affect my daily activities
___ I have had to change how I do things
___ I have had to stop doing some of my daily activities
___ I am unable to perform daily activities

27. What **increases** your pain? _____

28. What **decreases** your pain? _____

29. Have you ever experienced this problem before? [ ] Y [ ] N When? _____

30. Do you have a previous illness/disease which affects your present condition? ( ) Y ( ) N

If yes, please describe: _____

31. List any other complaints currently bothering you and rate your pain level for each.

a. _____ **0 1 2 3 4 5 6 7 8 9 10**
b. _____ **0 1 2 3 4 5 6 7 8 9 10**
c. _____ **0 1 2 3 4 5 6 7 8 9 10**
d. _____ **0 1 2 3 4 5 6 7 8 9 10**

32. Have you lost time from work as a result of this accident? ( ) Y ( ) N

a. Type of employment: _____
b. Last day worked: _____

33. Have you ever been involved in an accident before? ( ) Y ( ) N

a. If yes, when? _____
b. Describe the accident(s): _____

_____

c. Were you injured? [ ] Y [ ] N Explain:

_____

34. List all medication you are currently taking *(prescribed and over the counter)*

_____

35. List all surgeries you have had *(with date)*

_____

If you have experienced any of the following conditions in the past mark a "**P**" on the line provided. If you are currently experiencing any of the following conditions please mark a "**C**" on the line provided. *(check all that apply)*

___ heart attack
___ stroke
___ arthritis
___ gall bladder trouble
___ diabetes
___ glaucoma
___ fainting spells
___ kidney stones
___ difficulty with urination
___ bloody stools
___ difficulty with bowel movements
___ prostate trouble
___ anemia
___ cancer
___ asthma
___ AIDS
___ ulcers
___ diverticulosis
___ menstrual cramping
___ dizziness
___ loss of memory
___ chest pain
___ shortness of breath
___ constipation
___ diarrhea
___ general fatigue
___ sudden weight loss
___ nausea
___ muscle cramping
___ soreness in joints
___ loss of hearing
___ ears ringing
___ headache
___ migraine
___ epilepsy
___ gout
___ tuberculosis
___ syphilis
___ sprained ankle [ ] R [ ] L
___ knee/hip replacement
___ broken bones *(specify)*

General Activities *(check all that apply)*

___ sleep on waterbed	___ read in bed	___ fall asleep in recliner/on couch
___ sleep on stomach	___ needlepoint/knitting	___ use two or more pillows to sleep with
___ sewing	___ lift weights/wt. mach.	___ play video games (_____ hrs per day)
___ exercise _____x/wk	___ jog _____x/wk	___ computer use (_____ hrs per day)
___ swim	___ use healthrider	___ watch television (_____ hrs per day)

Please add anything else you would like the doctor to know: _____

_____

_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____

(signature of parent if the patient is a minor)

Doctor's Comments: _____