

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 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: _____

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.

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

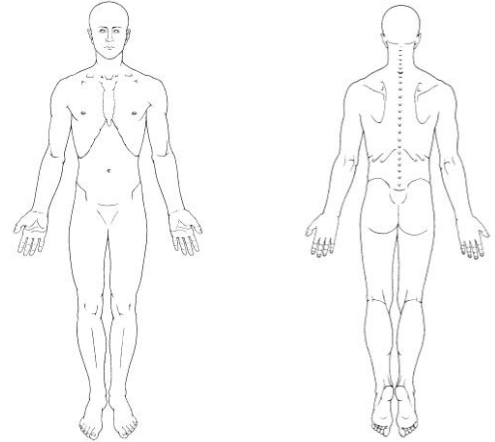
Type of pain? Sharp Dull Aching Burn Throb Numb Other _____

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? _____

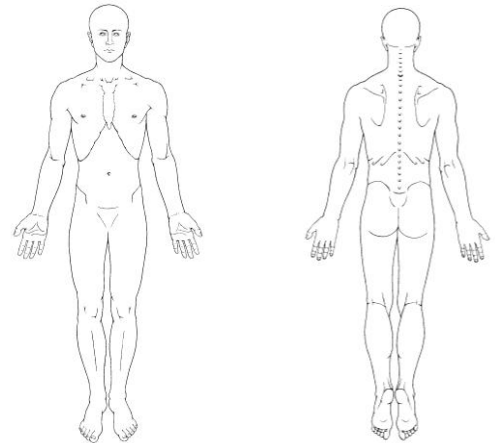
Type of pain? Sharp Dull Aching Burn Throb Numb Other _____

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? _____

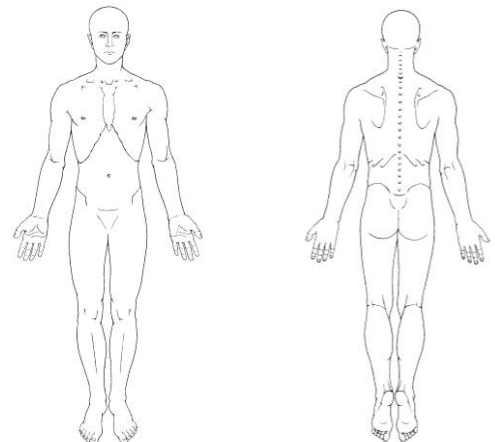
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Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

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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 hereby 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: _____