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.

☐ 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?____________________

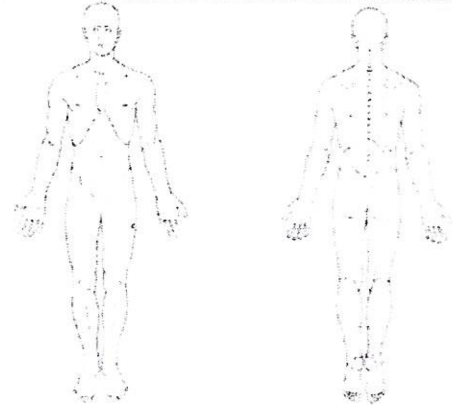
Type of pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burn ☐ Throb ☐ Numb ☐ Other________

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?____________________

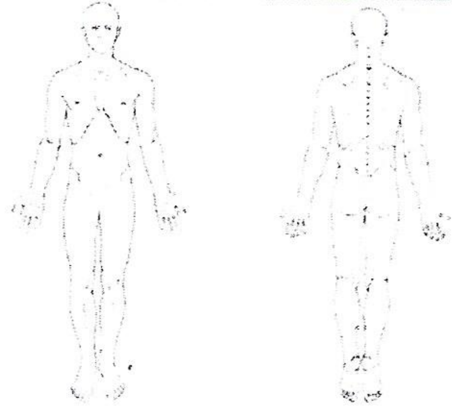
Type of pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Burn ☐ Throb ☐ Numb ☐ Other________

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