

Motor Vehicle Crash History

(Please Print)

Patient Information

Dr./Mr./Mrs./Ms./Miss (circle one)

Acct# _____

Marital Status (circle one) M S W D

Last Name First Name Middle Initial Nick Name

Address City State Zip Code

Mobile phone# _____ Home 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 provide the staff with you insurance card and/or necessary forms.

Crash/Injury History

1. Date of Crash: _____ 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 seatbelt? 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

(If you are not sure, leave direction questions blank)

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 crash?

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 explain: _____
- 12.** If your vehicle is equipped with air bags, did they activate? Y N
- 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.** Did you lose consciousness during the crash? Y N
If yes, for how long? _____
- 19.** Where were 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.** 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 effect your daily activities?

___It does not effect 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 pervious illness/disease which affects your present condition? Y N

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) _____

36. Please provide your medical doctors name _____

37. Please provide any previous chiropractors you have treated with _____

If you have experienced any of the following conditions in the past mark with 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)

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

General Activities (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> sleep on waterbed | <input type="checkbox"/> read in bed | <input type="checkbox"/> fall asleep in recliner/on couch |
| <input type="checkbox"/> sleep on stomach | <input type="checkbox"/> needlepoint/knitting | <input type="checkbox"/> use two or more pillows to sleep |
| <input type="checkbox"/> sewing | <input type="checkbox"/> lift weights.wt. mach. | <input type="checkbox"/> play video games (____hrs per day) |
| <input type="checkbox"/> jog____x/wk | <input type="checkbox"/> swim | <input type="checkbox"/> computer use (____hrs per day) |
| <input type="checkbox"/> exercise____x/wk | <input type="checkbox"/> use treadmill | <input type="checkbox"/> 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 my child or me 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: _____

