

Patient File#: _____



AUTO ACCIDENT HISTORY

WELCOME: The doctor and staff 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 to the best of your ability. Be as descriptive as possible and check all descriptors that apply. 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 Accident: ____ / ____ / ____

Insurance Information

AUTO ACCIDENT INSURANCE INFORMATION: If you have not completed an application of benefits from your 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: _____

1. I was the/a: _____

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? _____ Days

d. Did you receive any of the following: X-Ray CT Scan MRI Lab Work Treatment/Meds None

e. How did you get there? _____

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: _____

8. Were you wearing a seatbelt? Yes No

3. Second Vehicle Type: _____

9. Did your airbag deploy? Yes No

4. Third Vehicle Type: _____

10. Does your car have a headrest? Yes No

5. Road Conditions: _____

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

6. Road Type: _____

12. Head Position: _____

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

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

AUTO ACCIDENT HISTORY (cont'd)

14. Was your car moving before impact? Yes No If yes, how fast? _____(mph)
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)
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)
- If other area then describe:

COLLISION DETAILS (Describe how the cars collided. My vehicle was...)	COLLISION RESULTS ("During the accident my...")
19. First Impact: _____ (My car was hit in the...)_____	21. Body was thrown: _____
20. Second Impact: _____ (My car was hit in the...)_____	22. Head Hit: _____
	23. Chest Hit: _____
	24. Shoulders Hit: _____
	25. Knees Hit: _____
	26. Hips Hit: _____

VEHICLE DAMAGE

27. First Vehicle: _____ 28. Second Vehicle: _____ 29. Third Vehicle: _____
-

PERSONAL INJURY

30. Were you hospitalized? Yes No
(If yes, please answer the questions in the paragraph below.)
- a. How were you transported to the hospital? _____
 - b. What did the hospital recommend? _____
 - c. Did you have any x-rays, CT Scans or MRI's taken? Yes No
- If yes, what areas? _____
31. List all of your symptoms/complaints/conditions here: _____
32. Describe the quality of your symptoms: _____
33. How would you describe your current symptoms: Pain Numbness Stiffness Weakness None
- 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:*
34. on your daily functioning when you are at rest? _____ 35. on your daily functioning when you are active? _____
36. When did this condition originally begin? ____ / ____ / ____
37. Is your condition currently...? Worsening Stagnant Lessening
38. If your condition has worsened or is worsening, when did the increased symptoms start? ____ / ____ / ____

AUTO ACCIDENT HISTORY (cont'd)

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

40. Is your condition worse in the: Morning Afternoon Evening During Activity When resting
and is it mostly: Intermittent Constant Occassional None

41. Is your condition better in: Warm Temp Cold Temp Damp Sunny None

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

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

Headaches (Describe your headaches in detail): _____

(Describe the location and type of sensation): _____

Weakness (Describe the location): _____

Other not Listed (Describe): _____

44. Do your symptoms seem to be better with:

- | | | | | |
|-----------------------------------|-----------------------------------|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Activity | <input type="checkbox"/> Heat | <input type="checkbox"/> Nothing | <input type="checkbox"/> Rest | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Massage | <input type="checkbox"/> OTC Meds | <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Movement | <input type="checkbox"/> Prescription Meds | <input type="checkbox"/> Standing | |

PAST HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on any below that apply to you.

45. Please list any medications or nutritional supplements that you are currently taking:

46. Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided:

47. Childhood Illnesses (Please list any illnesses that you have had as a child):

48. Adult Illnesses (Please list any illnesses that you have had as a child):

49. Surgeries (Please list all surgical procedures that have had in the past):

50. Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past):

51. Immunizations (Please list any vaccinations that you have had):

52. Non Drug Allergies and how you react to those substances:

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient _____ Date _____ Date of Injury _____

Initial Update Final

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> My exercise was affected by this crash | <input type="checkbox"/> I have gained _____ pounds since the accident |
| <input type="checkbox"/> I go to the gym & work out in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I no longer go to the gym to work out | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I run but in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I no longer run | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I take walks & have pain while walking | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I no longer take walks | <input type="checkbox"/> I didn't enjoy the sport of _____ for ____ weeks |
| <input type="checkbox"/> I used to make income at sports | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I have lost sports income since crash | <input type="checkbox"/> I didn't enjoy the sport of _____ for ____ weeks |
| <input type="checkbox"/> I am an amateur athlete | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I am a professional athlete | <input type="checkbox"/> I didn't enjoy the sport of _____ for ____ weeks |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I didn't enjoy the sport of _____ for ____ weeks |

Please check all that apply to your HOBBY Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> My hobbies were affected by accident | <input type="checkbox"/> Hobby #3 _____ |
| <input type="checkbox"/> Hobby #1 _____ | <input type="checkbox"/> I can't do hobby #3 anymore |
| <input type="checkbox"/> I can't do hobby #1 anymore | <input type="checkbox"/> I do hobby #3 but in pain |
| <input type="checkbox"/> I do hobby #1 but in pain | <input type="checkbox"/> I have lost money from not doing #3 |
| <input type="checkbox"/> I have lost money from not doing #1 | <input type="checkbox"/> I didn't do hobby #3 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #1 for _____ weeks | <input type="checkbox"/> Hobby #4 _____ |
| <input type="checkbox"/> Hobby #2 _____ | <input type="checkbox"/> I can't do hobby #4 anymore |
| <input type="checkbox"/> I can't do hobby #2 anymore | <input type="checkbox"/> I do hobby #4 but in pain |
| <input type="checkbox"/> I do hobby #2 but in pain | <input type="checkbox"/> I have lost money from not doing #4 |
| <input type="checkbox"/> I have lost money from not doing #2 | <input type="checkbox"/> I didn't do hobby #4 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #2 for _____ weeks | <input type="checkbox"/> _____ |

Please check all that apply to your TRAVEL Activities because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> Business travel was affected by crash | <input type="checkbox"/> Travel Plan #1 _____ |
| <input type="checkbox"/> Pleasure travel was affected by crash | <input type="checkbox"/> I did not go on travel plan #1 |
| <input type="checkbox"/> I hurt driving in my own car | <input type="checkbox"/> I went, but did not enjoy #1 as much |
| <input type="checkbox"/> I am in too much pain to drive | <input type="checkbox"/> I went and the accident had no effect on #1 |
| <input type="checkbox"/> I hurt when a passenger in a car | <input type="checkbox"/> Travel Plan #2 _____ |
| <input type="checkbox"/> I am in too much pain to sit in a car | <input type="checkbox"/> I did not go on travel plan #2 |
| <input type="checkbox"/> I have anxiety when I'm in a car | <input type="checkbox"/> I went, but did not enjoy #2 as much |
| <input type="checkbox"/> I hurt when I'm on an airplane | <input type="checkbox"/> I went and the accident had no effect on #2 |
| <input type="checkbox"/> I am in too much pain to travel by plane | <input type="checkbox"/> I missed time with my family/friends b/c can't travel |

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient _____ Date _____ Date of Injury _____

Initial Update Final

Please check all the DAILY LIVING Activities that cause you pain because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Riding in a car |
| <input type="checkbox"/> Putting on pants | <input type="checkbox"/> Opening a jar |
| <input type="checkbox"/> Putting on shoes | <input type="checkbox"/> Lifting a pan when cooking |
| <input type="checkbox"/> Tying my shoes | <input type="checkbox"/> Closing the trunk on my car |
| <input type="checkbox"/> Putting on shirt | <input type="checkbox"/> Opening the garage door |
| <input type="checkbox"/> Combing my hair | <input type="checkbox"/> Using my home computer |
| <input type="checkbox"/> Drying my hair | <input type="checkbox"/> Climbing stairs |
| <input type="checkbox"/> Washing my hair | <input type="checkbox"/> Going down stairs |
| <input type="checkbox"/> Taking a shower | <input type="checkbox"/> Sexual activity |
| <input type="checkbox"/> Taking a bath | <input type="checkbox"/> Turning my head to left or right |
| <input type="checkbox"/> Leaning Forward | <input type="checkbox"/> Holding my head up all day |
| <input type="checkbox"/> Laying in bed | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Sitting in my favorite chair | <input type="checkbox"/> I have pain sitting & doing nothing |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Talking on the phone |
| <input type="checkbox"/> Going out with my friends | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Sitting in a restaurant | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Opening doors |
| <input type="checkbox"/> Driving to/from work | <input type="checkbox"/> Drying with a towel after a bath or shower |
| <input type="checkbox"/> Sitting in Church | <input type="checkbox"/> Life has become a chore just to do normal things |
| <input type="checkbox"/> Playing with my children | <input type="checkbox"/> It is depressing to live like this |
| <input type="checkbox"/> Caring for my children | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bending at the waist | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Sitting in a movie theater | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eating | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Brushing my teeth | <input type="checkbox"/> _____ |

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> School was affected by the accident | <input type="checkbox"/> I have pain carrying my school books |
| <input type="checkbox"/> I am a student at _____ | <input type="checkbox"/> I hurt sitting in class more than _____ minutes |
| <input type="checkbox"/> I am in the _____ year/grade | <input type="checkbox"/> My neck hurts when I look down to read |
| <input type="checkbox"/> I was <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn as quickly as before the crash |
| <input type="checkbox"/> I am now <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn things as well as before the crash |
| <input type="checkbox"/> I had to take fewer classes b/c of crash | <input type="checkbox"/> I have difficulty concentrating in class |
| <input type="checkbox"/> I missed _____ days of school | <input type="checkbox"/> It takes much longer to study/do my homework |
| <input type="checkbox"/> I had to drop out of school b/c of crash | <input type="checkbox"/> _____ |
| <input type="checkbox"/> My grades are lower since the crash | <input type="checkbox"/> _____ |

Signature of Patient _____

Date ____/____/____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

Initial Update Final

Please check all that apply to your WORK because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> I go to work but work in pain | <input type="checkbox"/> I work in pain because I have bills to pay |
| <input type="checkbox"/> I limit my work activities | <input type="checkbox"/> I can't take time off because I would lose my job |
| <input type="checkbox"/> Bending at work hurts | <input type="checkbox"/> I keep working so I don't lose status at company |
| <input type="checkbox"/> Stooping at work hurts | <input type="checkbox"/> My business would fail if I took time off |
| <input type="checkbox"/> Sitting at work hurts | <input type="checkbox"/> I believe in working even when I'm in pain |
| <input type="checkbox"/> Using the Computer at work hurts | <input type="checkbox"/> I feel obligated to work even though I'm in pain |
| <input type="checkbox"/> Pushing at work hurts | <input type="checkbox"/> My business would lose money if I took time off |
| <input type="checkbox"/> Pulling at work hurts | <input type="checkbox"/> My work is not as good as it was before accident |
| <input type="checkbox"/> Kneeling at work hurts | <input type="checkbox"/> My boss reprimanded me for poor performance |
| <input type="checkbox"/> I have lost status in my company | <input type="checkbox"/> I got a different job within the same company |
| <input type="checkbox"/> I have lost job security | <input type="checkbox"/> I got a different job in another company |
| <input type="checkbox"/> I didn't get a promotion | <input type="checkbox"/> I make less money than before the accident |
| <input type="checkbox"/> I don't enjoy work as much as before | <input type="checkbox"/> I cannot do the same work/job as before accident |
| <input type="checkbox"/> I doze off at work | <input type="checkbox"/> I can't concentrate as well at work |
| <input type="checkbox"/> I take unpaid time off work to go to Dr. | <input type="checkbox"/> I take paid time off to go to Dr. |
| <input type="checkbox"/> I daydream at work more than before | <input type="checkbox"/> I make mistakes at work I didn't used to |
| <input type="checkbox"/> I feel tired at work | <input type="checkbox"/> I hide my poor work performance from my boss |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

- | | |
|---|--|
| <input type="checkbox"/> My house is not as clean now | <input type="checkbox"/> I cannot take time off because I care for children |
| <input type="checkbox"/> My yard is not as neat now | <input type="checkbox"/> I have _____ children ages _____ |
| <input type="checkbox"/> My garden is not as productive now | <input type="checkbox"/> I had to hire a paid housekeeper |
| <input type="checkbox"/> I do yard work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid housekeeping help |
| <input type="checkbox"/> I cannot do my normal yard work | <input type="checkbox"/> I had to hire a paid gardener |
| <input type="checkbox"/> I do house work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid yard work help |
| <input type="checkbox"/> I cannot do my normal house work | <input type="checkbox"/> Mowing the lawn hurts me |
| <input type="checkbox"/> Doing laundry hurts me | <input type="checkbox"/> I cannot mow the lawn |
| <input type="checkbox"/> I cannot do laundry now | <input type="checkbox"/> Taking out the trash hurts me |
| <input type="checkbox"/> Washing dishes hurts me | <input type="checkbox"/> I cannot take out the trash |
| <input type="checkbox"/> I cannot wash dishes now | <input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to |
| <input type="checkbox"/> Vacuuming hurts me | <input type="checkbox"/> I do not enjoy my housework like I used to |
| <input type="checkbox"/> I cannot vacuum now | <input type="checkbox"/> Gardening hurts me |
| <input type="checkbox"/> Cooking hurts me | <input type="checkbox"/> I cannot do my gardening at all since the accident |
| <input type="checkbox"/> I cannot cook now | <input type="checkbox"/> Others living with me do my share of the work now |
| <input type="checkbox"/> Washing the car hurts me | <input type="checkbox"/> Others living with me do my share of the yard work |
| <input type="checkbox"/> I cannot wash my car | <input type="checkbox"/> Others living with me do my share of the gardening |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Signature _____

Date _____