Please provide us with a copy of the accident report on your next visit.

AUTOMOBILE ACCIDENT HISTORY

PLEASE PRINT:

NAME: _____ DATE: _____

DATE OF ACCIDENT: _____ TIME: _____ ❑ AM ❑ PM

DRIVER OF VEHICLE: _____ WHERE WERE YOU SEATED? _____

VEHICLE'S OWNER: _____ YEAR AND MODEL OF VEHICLE YOU WERE IN: _____

YEAR AND MODEL OF THE OTHER VEHICLE(S) IN THE COLLISION: _____

NUMBER OF VEHICLES IN THE COLLISION: ❑ 1 ❑ 2 ❑ 3 ❑ OTHER: _____

WHAT WAS THE APPROXIMATE DAMAGE DONE TO THE VEHICLE YOU WERE IN? $ _____

WHERE DID THE ACCIDENT OCCUR? _____

VISIBILITY AT THE TIME OF ACCIDENT: ❑ POOR ❑ FAIR ❑ GOOD

ROAD CONDITIONS AT THE TIME OF THE ACCIDENT: ❑ ICY ❑ RAINY ❑ WET ❑ CLEAR ❑ DARK

YOUR VEHICLE: ❑ HIT ANOTHER VEHICLE ❑ WAS HIT IN THE: ❑ RIGHT SIDE ❑ LEFT SIDE ❑ REAR ❑ FRONT

TYPE OF ACCIDENT: ❑ HEAD-ON COLLISION ❑ BROAD-SIDE COLLISION ❑ REAR-END COLLISION
❑ FRONT-IMPACT, REAR-ENDED VEHICLE IN FRONT ❑ SINGLE VEHICLE COLLISION
❑ OTHER (EXPLAIN): _____

WERE THE INTERNAL VEHICLE PARTS BROKEN? ❑ YES ❑ NO

IF YES: ❑ WINDSHIELD ❑ RIGHT PASSENGER WINDOW ❑ LEFT PASSENGER WINDOW
❑ STEERING WHEEL ❑ FRONT SEAT BACK ❑ REAR VIEW MIRROR ❑ OTHER _____

IMPACT/SEAT BELT/HEADREST/SPEED/HEAD/BODY POSITION

DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED TO YOU UPON IMPACT: _____

_____

❑ YES ❑ NO DID YOU SEE THE ACCIDENT COMING?

❑ YES ❑ NO WERE YOU PRE-WARNED THAT THE ACCIDENT WAS ABOUT TO HAPPEN?

❑ YES ❑ NO DID YOU BRACE FOR THE IMPACT?

❑ YES ❑ NO DID YOU HAVE YOUR HANDS ON THE STEERING WHEEL AT IMPACT?

HEAD/BODY POSITION AT THE TIME OF IMPACT:

HEAD:	❑ STRAIGHT	❑ TURNED RIGHT	❑ TURNED LEFT
BODY:	❑ STRAIGHT	❑ TURNED RIGHT	❑ TURNED LEFT

AT THE TIME OF THE ACCIDENT, WHAT PARTS OF YOUR HEAD/BODY HIT WHAT PARTS OF THE INSIDE OF THE VEHICLE: _____

_____

❑ YES ❑ NO WERE YOU WEARING GLASSES, A HAT, OR DENTURES? WHERE WERE THEY AFTER THE ACCIDENT? _____

❑ YES ❑ NO WERE SEAT BELTS WORN? ❑ YES ❑ NO WERE SHOULDER HARNESSES WORN? ❑ YES ❑ NO DID THEY ENGAGE?

❑ YES ❑ NO DOES YOUR VEHICLE HAVE AIR BAGS? ❑ SINGLE ❑ DUAL ❑ OTHER _____

❑ YES ❑ NO DID YOUR AIR BAG RELEASE? ❑ ONE ❑ BOTH ❑ OTHER _____

❑ YES ❑ NO DOES YOUR VEHICLE HAVE HEADRESTS? IF YES, WHAT WAS ITS POSITION COMPARED TO YOUR HEAD BEFORE THE ACCIDENT?
TOP OF HEADREST EVEN WITH ❑ MIDDLE OF NECK ❑ TOP OF HEAD ❑ BOTTOM OF HEAD
DISTANCE FROM BACK OF HEAD TO FRONT OF HEAD REST (APPROXIMATE INCHES) _____

❑ YES ❑ NO WAS YOUR VEHICLE BRAKING?

❑ YES ❑ NO WAS YOUR VEHICLE MOVING AT THE TIME OF THE ACCIDENT? ❑ SLOWING DOWN ❑ SPEEDING UP ❑ CONSTANT SPEED
WHAT WAS THE SPEED LIMIT ON THE ROAD YOU WERE TRAVELING? _____ MPH

HOW MANY PEOPLE WERE IN YOUR VEHICLE? _____

ABILITY TO MOVE BODY

WHERE WERE YOU IN THE VEHICLE PRIOR TO THE ACCIDENT? _____
AFTER THE ACCIDENT? _____

AS A RESULT OF THE ACCIDENT, WERE YOU:
❑ RENDERED UNCONSCIOUS ❑ DAZED, SITUATION VAGUE ❑ SHAKEN UP BUT COULD FUNCTION

❑ YES ❑ NO COULD YOU MOVE ALL PARTS OF YOUR BODY? IF NO, WHAT PARTS AND WHY NOT? _____

_____

❑ YES ❑ NO WERE YOU ABLE TO GET OUT OF THE VEHICLE UNAIDED? IF NO, WHY NOT? _____

_____

SYMPTOMS FROM ACCIDENT

❑ YES ❑ NO DID YOU RECEIVE ANY BRUISES FROM THE SEATBELTS? IF SO, WHERE? _____

❑ YES ❑ NO DID YOU RECEIVE ANY OTHER BLEEDING CUTS OR BRUISES? IF CUT, WHERE? _____
IF BRUISES, WHERE? _____

PLEASE DESCRIBE HOW YOU FELT. PLEASE BE SPECIFIC.
IMMEDIATELY AFTER THE ACCIDENT: _____
LATER THAT ❑ DAY ❑ NIGHT: _____
THE NEXT DAY(S): _____

GENERAL SYSTEMS UPDATE

CHECK SYMPTOMS THAT HAVE BECOME APPARENT SINCE THE ACCIDENT/INJURY:

1. ❑ NERVOUSNESS
2. ❑ NECK PAIN/STIFFNESS
3. ❑ MIDBACK PAIN
4. ❑ LOW BACK PAIN
5. ❑ EYES SENSITIVE TO LIGHT
6. ❑ PAIN BEHIND EYES
7. ❑ DIZZINESS
8. ❑ COLD SWEATS
9. ❑ FACE FLUSHED
10. ❑ RINGING/BUZZING EARS
11. ❑ LOSS OF BALANCE
12. ❑ LOSS OF SMELL
13. ❑ LOSS OF TASTE
14. ❑ LOSS OF MEMORY
15. ❑ PINS & NEEDLES - ARMS
16. ❑ PINS & NEEDLES - LEGS
17. ❑ SHORTNESS OF BREATH
18. ❑ HEAD SEEMS TOO HEAVY
19. ❑ IRRITABILITY
20. ❑ DEPRESSION
21. ❑ SLEEPING TROUBLE
22. ❑ TOE NUMBNESS
23. ❑ FINGER NUMBNESS
24. ❑ COLD HANDS
25. ❑ COLD FEET
26. ❑ CHEST PAIN
27. ❑ CONSTIPATION
28. ❑ DIARRHEA
29. ❑ FATIGUE
30. ❑ TENSION
31. ❑ FEVER
32. ❑ HEADACHE
33. ❑ FAINTING
34. ❑ ANXIETY
35. ❑ SEIZURES
36. ❑ VISUAL DISTURBANCES
37. ❑ FORGETFULNESS
38. ❑ BLURRED VISION
39. ❑ DOUBLE VISION
40. ❑ CONFUSED
41. ❑ DISORIENTED
42. ❑ OTHER _____

WORK STATUS HISTORY

OCCUPATION: _____ EMPLOYER: _____

❑ YES ❑ NO HAVE YOU MISSED TIME FROM WORK? IF NO, WHO TOLD YOU TO RETURN TO WORK? _____

IF YES, ❑ OFF WORK FULL-TIME DATES: _____

❑ OFF WORK PART-TIME DATES: _____

❑ UNABLE TO RETURN TO WORK SINCE ACCIDENT.

WHAT TYPE OF PHYSICAL ACTIVITY IS REQUIRED AT WORK? _____

❑ YES ❑ NO IS THERE ALTERNATIVE WORK AVAILABLE?

FIRST DOCTOR/HOSPITAL/CLINIC

❑ YES ❑ NO DID YOU SEEK MEDICAL HELP IMMEDIATELY AFTER THE ACCIDENT? IF YES, HOW DID YOU GET THERE?

❑ SOMEONE ELSE DROVE ME ❑ DROVE OWN VEHICLE ❑ POLICE ❑ AMBULANCE

DOCTOR/HOSPITAL/CLINIC: _____ DATE OF FIRST VISIT: _____

❑ YES ❑ NO WERE YOU EXAMINED? ❑ YES ❑ NO WERE X-RAYS TAKEN?

WHAT DIAGNOSIS DID THE DOCTOR GIVE YOU? _____

❑ YES ❑ NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE? _____

WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT? _____

DATE OF LAST TREATMENT: _____

❑ YES ❑ NO DID THE DOCTOR REFER YOU TO ANOTHER HEALTH PROFESSIONAL? IF YES, TO WHO AND FOR WHAT? _____

❑ YES ❑ NO DID YOU FOLLOW THE DOCTOR'S RECOMMENDATION? IF NO, WHY NOT? _____

SECOND DOCTOR/CLINIC

DOCTOR/CLINIC: _____ DATE OF FIRST VISIT: _____

❑ YES ❑ NO WERE YOU EXAMINED? ❑ YES ❑ NO WERE X-RAYS TAKEN?

❑ YES ❑ NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE? _____

WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT? _____

DATE OF LAST TREATMENT: _____

PRIOR SIMILAR SYMPTOMS

❑ YES ❑ NO DID YOU HAVE ANY PHYSICAL COMPLICATIONS JUST BEFORE THE ACCIDENT? IF YES, PLEASE DESCRIBE IN DETAIL: _____

❑ YES ❑ NO PRIOR TO THIS ACCIDENT, HAVE YOU EVER HAD SIMILAR SYMPTOMS? IF YES, PLEASE EXPLAIN (FALLS, INJURIES, ETC.) _____

❑ YES ❑ NO HAVE YOU BEEN IN ACCIDENTS PRIOR TO THIS ONE? IF YES, WHEN? _____ WHERE? _____

HOW WAS IT TREATED? _____ RESULT OF TREATMENT: _____

❑ YES ❑ NO ARE YOU NOW BEING TREATED?

❑ YES ❑ NO DO YOU HAVE ANY CONGENITAL (BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM? IF YES, PLEASE DESCRIBE: _____

ADDITIONAL COMMENTS