ACCIDENT HISTORY FORM

Full Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Occupation _____light duty_____regular duty___

Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Age _____ Email: _____

Birthday _____/_____/_____ No. of children ____ Are you currently pregnant? ☐ Yes ☐No

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other _____ SS# _____

*Email _____

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

HISTORY OF ACCIDENT (check all that apply)

1. **Date of Accident** _____
2. Description of Accident _____

_____

_____

3. ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other _____
4. Was anyone in the vehicle with you? ☐ Yes ☐ No If Yes, _____
5. Were you wearing a **seat belt**? ☐ Yes ☐ No If yes, did it have a shoulder harness? ☐ Yes ☐ No
6. Did your vehicle have an air bag? ☐ Yes ☐ no If yes, did it deploy? ☐ Yes ☐ No
7. Did you strike any objects in the car? ☐ Yes ☐ No
8. If yes, then what? ☐ Airbag ☐ Armrest ☐ Center console ☐ Dashboard ☐ Gear shift/knob ☐ Headrest ☐ Rearview mirror
   ☐ Roof ☐ Rear window ☐ Seatback ☐ Side door ☐ Steering wheel ☐ Windshield ☐ Other _____
9. What portion of your body did you strike? ☐ Head ☐ Chest ☐ Face ☐ Arms ☐ Hands ☐ Legs ☐ Knees
   ☐ Shoulder ☐ Hip ☐ Other _____
10. Did you see the accident coming? ☐ Yes ☐ No If yes, were you braced for impact? ☐ Yes ☐ No
11. Did your vehicle have headrests? ☐ Yes ☐ No
12. What was the position of the **headrest**? ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck ☐ Other _____
13. What was the position of your head at impact? ☐ Facing straight ☐ Turned Left ☐ Turned Right ☐ Other _____
14. As a result of the accident did you experience any of the following? ☐ Dazed ☐ Unconscious ☐ Bruises ☐ Scraps ☐ Cuts
    ☐ Swelling ☐ Fractures ☐ Burns ☐ No Injuries ☐ Other _____
15. If yes to #14, please explain_____

_____

16. If you experienced pain immediately after the accident, please indicate where:

☐	Headache	☐ Left	☐ Right	☐	Neck pain	☐ Left	☐ Right
☐	Upper-back pain	☐ Left	☐ Right	☐	Mid-back pain	☐ Left	☐ Right
☐	Chest pain	☐ Left	☐ Right	☐	Low-back pain	☐ Left	☐ Right
☐	Arm	☐ Left	☐ Right	☐	Elbow	☐ Left	☐ Right
☐	Knee	☐ Left	☐ Right	☐	Leg	☐ Left	☐ Right
☐	Other _____						

17. After the accident, did you go to the hospital? ☐ Yes ☐ No

HOSPITALIZATION

18. What was the Name of the Hospital?_____

19. What was performed at the Hospital? □ Examination □ X-Rays □ MRI □ CT-Scan □ Blood work □ Lab work □ Surgery □ Prescriptions given □ Other_____

(If patient consulted this office, skip to PAST HISTORY)

20. Have you seen any other Doctors for this accident? Dr.'s Name _____ □ Family Physician □ Chiropractor □ Orthopedist □ Osteopath □ Neurologist □ Other _____

21. What did the doctor(s) do? □ Examination □ Chiropractic manipulation □ X-rays □ Injections □ Physiotherapy □ Prescription(s) □ Other _____

22. How long were you under this doctor's care? _____

23. Are you still under this doctor's care? □ Yes □ No

24. Frequency or number of visits now? _____

25. Did the doctor refer you to or have you been to any other physician? □ Yes □ No
If yes, explain: _____

26. Were you sent for an independent medical examination? □ Yes □ No
If yes, to whom? _____

27. Other pertinent information _____

28. Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

□ Cancer □ Depression □ Heart disease □ Hepatitis □ Pacemaker □ High blood pressure □ Stroke □ Pulmonary Disease □ Pregnancies □ Other _____

29. For patients over 13 yrs. Old. □ Smoking –packs per day ____ □ alcohol drinks/week _____ □ coffee/caffeine drinks-cups/day____

30. Please list all allergies including **allergies** to medications_____

_____

31. List all **medications** you are currently taking (including vitamins & supplements) _____

_____

32. List any **surgeries, fractures, serious illnesses, or hospitalizations**._____

_____

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33. Have you ever been in any **previous accident** of any kind? (Including auto, work related, or slip and fall) □ Yes □ No
If yes, please give dates and details _____

_____

34. Were you rendered **permanently impaired**? □ Yes what % _____ □ No

35. Has any other physician **prior** to this accident ever treated you for **neck or back problems**? □ Yes □ No
If yes, please explain _____

_____

36. Have you had any previous **surgeries** or any conditions that I should know about? □ Yes □ No
If yes, please explain _____

_____

37. Were you symptom free and in good health before this accident? □ Yes □ No
If no, please explain _____

_____

PRESENT COMPLAINTS

38. Since the accident are your symptoms □ improving □ staying the same □ getting worse

_____

39. Please list your current problem areas (prioritize with worst being #1) please use diagram attached for description as well.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

40. Have you lost any time from work since the accident? □ Yes □ No

41. If yes, how many days? _____ Are you still off work? □ Yes □ No

42. Date returned _____

43. In what way have your injuries affected your ability to work? _____

_____

44. Can you perform your **normal** physical work activities? □ Yes □ No if no why_____

45. Please check the following you are having problems with □ standing □ sitting □ walking □ seeing □ hearing □ tasting □ smelling □ eating □ reading □ writing □ holding □ climbing □ bending □ twisting □ carrying □ lifting □ pulling □ pushing □exercising □ Loss of sexual drive □ restful sleeping □ irritability □ nervousness □ loss of concentration □ driving □ other_____

46. If you have an attorney representing you, please give name, address, and telephone number:

Name _____ Firm _____

Address _____City _____

State _____ Zip _____ Phone _____

I certify that all of the above personal health information on pages one, two, three, & four are complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition in the future.

Patient Signature or guardian _____ Date _____