Motor Vehicle Crash History
(Please Print)

Patient Information **Acct#**_____

Dr./Mr./Mrs./Ms./Miss (circle one) Marital status (circle one) M S W D

_____

Last Name First Name Middle Initial Nick Name

_____

Address City State Zip Code

Home phone#_____ Mobile 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 your insurance card and/or required 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 seat belt? [ ] 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 describe:_____
12. If your vehicle was 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 you 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. How do you feel now, 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 affect your daily activities?

___ It does not affect 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 previous illness/disease which affects your present condition? [ ] Y [ ] N

If yes, please describe: _____

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)*

_____

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

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

General Activities *(check all that apply)*

___ sleep on waterbed
___ sleep on stomach
___ sewing
___ exercise _____x/wk
___ swim
___ read in bed
___ needlepoint/knitting
___ lift weights/wt. mach.
___ jog _____x/wk
___ use healthrider
___ fall asleep in recliner/on couch
___ use two or more pillows to sleep with
___ play video games (_____ hrs per day)
___ computer use (_____ hrs per day)
___ 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 me or my child 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:_____

_____

_____

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_____ _____ _____ _____

_____ _____