AUTOMOBILE ACCIDENT

Patient Name ________________________________ Today's Date ____________ Date of Accident ____________

1. YOUR VEHICLE TYPE

☐Car ☐Station Wagon
☐Van ☐Pickup Truck
☐Bus ☐Large Truck
☐Other ___________________

2. YOUR POSITION IN VEHICLE

☐Driver ☐Front Passenger
☐Left Rear Passenger
☐Right Rear Passenger
☐Other _______________

3. WHAT WAS YOUR VEHICLE DOING AT THE TIME OF ACCIDENT?

☐Stopped at intersection ☐Stopped in Traffic ☐Stopped at Light
☐Making a right turn ☐Making a left turn ☐Parking
☐Proceeding along ☐Slowing down ☐Accelerating
☐Other ____________________________

4. TIME/SPEED/DAMAGE

Time of Accident ______________________
Your vehicle's speed: _______________ mph
Their vehicles speed: _______________ mph

Damage to your vehicle:
☐Mild ☐Moderate ☐Totaled
Was your vehicle towed from the scene?
____

5. DETAILS OF ACCIDENT

Visibility at time of accident:
☐Poor ☐ Fair ☐Good

Who hit who / what?
☐ You hit other vehicle
☐ Other vehicle hit you
☐You hit… (object)
____

6. ROAD CONDITIONS

Road conditions at time of accident:
☐Icy ☐Wet ☐Sandy
☐Dark ☐Clean and dry

Point of impact:
☐Head-On ☐Left front ☐Right front
☐Rear-end ☐Left rear ☐Right rear

7. BODY POSITION, ETC.

Did you see the accident coming? ☐Yes ☐No
Were you braced for the impact? ☐Yes ☐No
Did you have a seat belt on? ☐Yes ☐No
Did you have a shoulder harness on? ☐Yes ☐No

Does your vehicle have headrests? ☐Yes ☐No
What was the position of your headrest at the time of impact?
☐Even with top of head ☐Even with bottom of head ☐Middle of neck
What was the direction of your head at the time of impact?
☐Facing straight forward ☐Turned to the right ☐Turned to the left

Did driver side airbags deploy? ☐Yes ☐No Did passenger side airbags deploy? ☐Yes ☐No Did side airbags deploy? ☐Yes ☐No

8. ADDITIONAL ACCIDENT INFORMATION

In case of a motor vehicle accident, enter any additional information here that is not covered by the above checkoffs.

9. DURING THE ACCIDENT

Did your body strike the inside of the vehicle? ☐Yes ☐No
If yes, describe: ____
Did you lose consciousness during the injury? ☐Yes ☐No
If yes, for how long? ____

Did police show up at the scene? ☐Yes ☐No
Was an accident report filled out? ☐Yes ☐No

10. AFTER THE ACCIDENT

Check off **ANY** symptoms since the accident.

☐Headache ☐Dizziness ☐Mid back pain ☐Cold hands
☐Neck pain ☐Nausea ☐Low back pain ☐Cold feet
☐Neck stiffness ☐Confusion ☐Nervousness ☐Diarrhea
☐Fainting ☐Fatigue ☐Loss of taste ☐Depression
☐Ringing in ears ☐Tension ☐Toe numbness ☐Anxious
☐Loss of smell ☐Irritability ☐Constipation ☐Chest pain
☐Pain behind eyes ☐Shortness of breath ☐Sleeping problems
☐Others ____

11. EMERGENCY ROOM?

Where did you go after the accident?
☐Home ☐Work ☐Hospital ER ☐Private doctor
How did you get there?
☐Drove self ☐Somebody else ☐Ambulance ☐Police
Were X-rays done? ☐Yes ☐No Was lab work done? ☐Yes ☐No
Body parts X-rayed? ______________________________________
What lab work? ____
The X-rays revealed: ______________________________________
Treatments: ☐Neck collar ☐Ice ☐Other:____________________
Medications: ____
Follow-up instructions: ___________________________________
____

12. TREATMENT HISTORY

Fill in any doctor(s) seen prior to your first visit in this office
1. Dr. ____________________________ First visit date ____/____/____
Specialty: __________________________ X-rays done? ☐Yes ☐No
Types of treatments received: ___________________________________
How many treatments received? _____ Currently treating? ☐Yes ☐No
Did Treatments benefit you? ☐Yes ☐No
Last visit date: ____/____/____
2. Dr. ____________________________ First visit date ____/____/____
Types of treatments received: ___________________________________
How many treatments received? _____ Currently treating? ☐Yes ☐No
Did Treatments benefit you? ☐Yes ☐No
Last visit date: ____/____/____

Patient / Parent Signature:____ Date:__________________________

I certify that the questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Name of patient: ____

Today's Date: ______________ Date Of Accident: ________________

Loss of Enjoyment/ Duties Under Duress Summary

Please complete the following questionnaire as it relates to how your injuries affect your performance of your living and work duties. Place a check mark in front of the day-to-day **living or work activities that are painful or difficult for you to perform as a result of the injuries** you sustained. Check the appropriate box designating reason for difficulty. Include those duties/ responsibilities, which require that you reduce the time that you are capable of performing them.

Please print clearly in black ink.

Job description: ____

N/A	Work	Reason for Difficulty/Limitation			
___	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Other: ________	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A	Studies/School	Reason for Difficulty/Limitation			
___	Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Walking	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Studying	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Concentration	☐ Increased Pain	☐ Headache	☐ Fatigue	☐ Blurry Vision
___	Other: ________	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A	Domestic Duties	Reason for Difficulty/Limitation			
___	Vacumming	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Taking Care of Kids	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Cleaning	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Preparing Meals	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Laundry	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Other: ________	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform

N/A	Household Duties	Reason for Difficulty/Limitation			
___	Yardwork	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Transportation	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Shopping	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue	☐ Cannot Perform
___	Taking Out Trash	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
___	Gardening	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue	☐ Cannot perform
___	Other: ________	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform

N/A Sports	Reason for Difficulty/Limitation			
Type of Sport: ____________________	☐ Increased Pain	☐ Restricted Movement	☐ Weakness	☐ Cannot Perform
Level of Participation Before Accident:	☐ Professional	☐ Competitively	☐ Socially	

Patient / Parent Signature:____ Date:___________________________

I certify that the questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.