PATIENT FILL-IN ACCIDENT HISTORY

Automobile Accident/P.I.

Name:_____ Date: _____

Date of Accident: _____ Date of EXAMINATION: _____

HISTORY: - Automobile Accident/P.I.

____ Driver ____ Passenger ____ Pedestrian ____Other:_____

Traveling Direction or Stopped facing: NORTH SOUTH EAST WEST
Estimated speed of patient's vehicle: _____ Estimated speed of other vehicle: _____
Location of Accident: Street:_____ City:_____ State:_____

DESCRIPTION OF ACCIDENT ***(Check and/or circle the appropriate description)***

_____ Stopped/slowing down for traffic/red light/stop sign) and was rear-ended by another vehicle.
_____ Was pushed into the vehicle in front of his/hers.
_____ Slowing down to execute a turn and was struck in the rear by another vehicle.
_____ Was side swiped by another vehicle traveling in the same direction.
_____ Another vehicle ran a (red light/stop sign) and struck (his/her) vehicle broadside/in the rear/in the front.
_____ The vehicle in which (he/she) was riding, was struck by another vehicle causing it to spin/roll over.
_____ Involved in a multi-car collision.
_____ Was thrown from the vehicle to the pavement/ground/outside object/another vehicle.
_____ Was a pedestrian and was struck by a motor vehicle in an accident.
_____ Other (brief description): _____
_____
_____

Did the vehicle have seatbelts? YES NO Were you braced for the impact? YES NO
Were you wearing seatbelt? YES NO Were the brakes applied? YES NO
List your seat position in the vehicle: _____
Was the position of your headrest: _____ Directly behind your head
_____ Below the mid point of the back of your head.
_____ Absent
At the time of impact, was the position of your head: STRAIGHT TURNED RT. TURNED LT.
Did you strike any object inside the car? YES NO
Which body parts struck any objects at the time of impact:
_____Head _____Face _____Chest _____Neck _____Back _____Shoulder (Rt/Lt)
_____Arm (Lt/Rt) _____Knee (Rt/Lt) _____Leg (Rt/Lt) Other:_____
Which objects were struck:
_____Windshield _____ Headrest _____ Dash Board
_____ Steering Column _____ Door Frame _____ Rear view mirror
_____ Back of seat _____ Seat broke _____ Cannot remember
_____ Other: _____
Were you rendered: _____ Unconscious _____ Cut or Bleeding _____ Neither
If applicable, indicate any pains or abnormal sensations experienced, immediately following the accident:
_____ Felt no immediate pain. _____ Pain began several hours/days/weeks after accident.
_____ Headache _____ Saw stars
_____ Semi-conscious state _____ Neck Pain (Rt/Lt)
_____ Mid back pain (Rt/Lt) _____ Low back pain (Rt/Lt)
_____ Upper extremity pain (Rt/Lt) _____ Lower extremity pain (Rt/Lt)
_____ Other: _____

Indicate any actions taken immediately following the accident:

_____ Went home and took it easy.
_____ Went about normal business.
_____ Went to other Chiropractic office.
_____ Went to hospital.
_____ Went to family physician.
_____ Used over-the-counter medications thinking symptoms would eventually "go away".

HOSPITALIZATION: ***(If no hospital visit, skip to next section)***

Indicate method of delivery to hospital: _____ Ambulance _____ Driven by family, friend, etc.
_____ Drove yourself _____ Other:_____
Hospital: ____ Sacred Heart ____ Luther Midelfort _____ Other: _____
Were you seen in the emergency room? YES NO
Were you admitted to the hospital? YES NO (If yes, length of stay? _____)
Indicate which procedures were performed while at hospital (including emergency room):

_____ Examination _____ Stitches _____ X-rays
_____ Prescription/Meds _____ Injections _____ Surgery
_____ Wounds dressed _____ Physical Therapy _____ Bed Rest

What did you do after being released from hospital? _____

Who was the first physician you consulted after this accident? *(If this is first office, skip to PAST HISTORY)*

Name & office location: _____
Was this physician: _____ Family Physician _____ Chiropractor
_____ Neurologist _____ Orthopedist
_____ OBGYN _____ Other: _____
What procedures were conducted: _____ Examination _____ X-rays
_____ Traction _____ Given medications.
_____ Manipulation _____ Refer to Physical Therapy
_____ Other: _____
If Physical Therapy was used, where did you receive therapy? _____
Have you seen other physicians since the above physician? YES NO
If yes, name & location of phycisian(s): _____
Are you still under the care of the physician(s)? YES NO

PAST HISTORY:

Has the patient been involved in any previous automobile accidents, of any kind? YES NO
If yes, indicates dates & details: _____
_____
_____
Have you ever been treated for any other past conditions that might relate to the injuries you have suffered in this recent accident? YES NO If yes, explain: _____
_____
_____
Have you ever undergone any surgeries or experienced any conditions that you feel are pertinent to your current condition? YES NO If yes, explain: _____
_____
_____
Did you enjoy good health prior to this accident? YES NO – explain: _____

NOTE: ***Be sure to indicate all your current complaints on the form entitled "Chiropractic Registration and History Form".***