Motor Vehicle Collision Information

Date: _____ DOI: _____

Name: _____ Age: _____ DOB: _____ Height: _____ Weight: _____

Gender: M / F: Handedness: R / L /A: Race_____ Occupation: _____FT / PT

Please list your current health concerns related to the collision in order of priority:

_____

_____

_____

Time of collision? _____am/pm Were you the driver? ___ Passenger ___ front seat ___ back seat ___

Year and Model of your vehicle_____ People in your vehicle _____

Names: _____

What direction were you traveling? N ___S___E___W___ Street _____

Where you stopped? Yes ____No ____ If no, your Est. speed_____ Struck from the F ___R___P___D___

Year and Model of other vehicle(s)_____

What direction of other vehicle? N ___S___E___W___ Street _____

Where they stopped? Yes ____No ____ If no, their Est. speed_____ Struck from the F ___R___P___D___

Road Conditions? Wet ___ Dry ___ Visibility? Good ___ Poor ___ Wearing a seat belt? Yes _____No _____

With shoulder harness? Yes _____No _____ Were you aware of the impending collision? Yes _____No_____

If yes, did you brace and how?_____ Did the air bags deploy? Yes _____No _____

Were the police notified? Yes ____No ____ If yes, was a report filed? Yes ____No ____

Please describe the collision in your own words: _____

_____

_____

_____

_____

What was your head position at time of impact? _____

Did your body collide with anything during the collision? Yes ____No ____ If yes, please explain:

_____

Did you lose consciousness during or after the collision? Yes ____No ____ If yes, please explain:

_____

Were contents in your car displaced during the collision? Yes ____No ____ If yes, please explain:

_____

Were you taken anywhere after the collision? Yes ____No ____ If yes, please explain:

_____

What were you thinking during the collision? _____

How did you feel immediately following the collision? _____

_____

_____

_____

Motor Vehicle Collision Information

Name: _____ Date of Birth: _____

How did you feel later that day? _____

_____

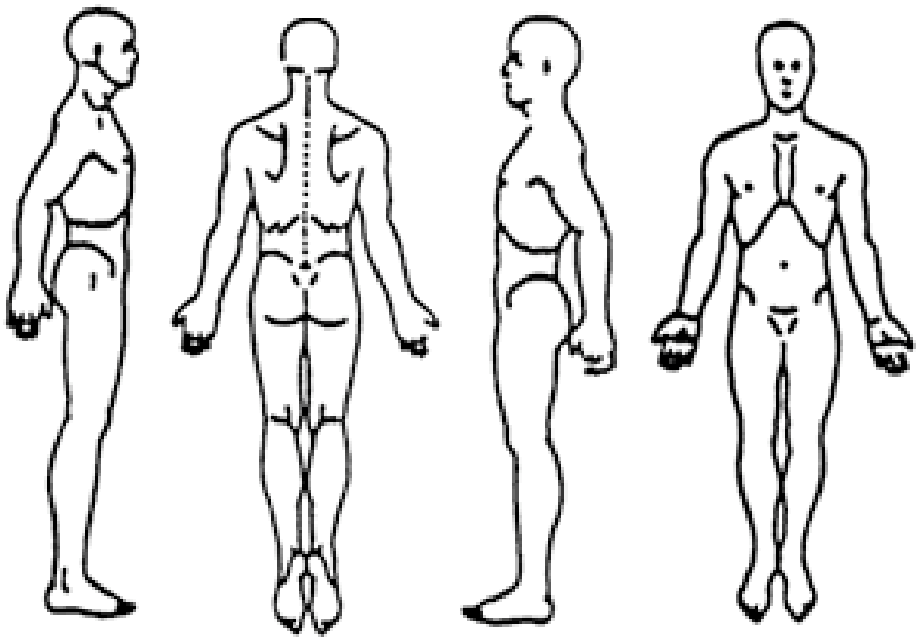
_____

How did you feel the following days? _____

_____

_____

Please mark all areas of pain on the diagram:



Have you been treated by any health care provider(s) for injuries from the collision? Yes ____No ____

If yes please provide names, dates of 1st visits and phone numbers: _____

_____

_____

What types of treatments and/or medications have you tried related to the collision, if any?

_____

_____

Did the collision occur while performing your job duties? Yes ____No ____ If yes, please explain:

_____

Has your condition impaired performing your job duties? Yes ____No ____ If yes, please explain:

_____

Have you lost time from work as a result of this collision? Yes ____No ____ If yes, please explain:

_____

How do these condition(s) impair your daily activities? _____

_____

_____

Motor Vehicle Collision Information

Name: _____ Date of Birth: _____

How do these condition(s) impair your social activities? _____

_____

What makes your condition it better? _____

What makes your condition it worse? _____

Did you have any physical complaints prior to the collision? Yes ____No ____ If yes, please explain:

_____

Have you ever been involved in a motor vehicle collision before? Yes ____No ____ If yes, were you injured and where? _____

_____

If you have experience any of the following conditions in the past please mark (P) on the line provided.
If you are currently experiencing any of the following conditions please mark (C) on the line provided.

____Heart Attack
____Stroke
____High BP
____Diabetes
____Cancer
____Arthritis
____Kidney Stones
____Gall Bladder
____Prostate Problems
____Nausea/Vomiting
____Dizziness
____Headache
____Memory Loss
____Fainting
____Hearing Loss
____Ringing in Ears
____Asthma
____Diarrhea
____Constipation
____Trouble Swallowing
____Indigestion/Reflux
____ Abdominal Pain
____Difficulty w/ Urination
____Blood in Urine
____Blood in Stool
____Gout
____Muscle pain
____Joint Replacement
____Joint pain
____Unexplained Fatigue
____Unexplained Weight Loss
____Unexplained Weight Gain
____Recent Fever / Sweats
____Chest Pains Discomfort
____ Palpitations
____ Shortness of Breath
____ Anxiety/Stress
____ Sleep Problems
____ Coughing /Wheezing
____Change in Vision
____Glaucoma
____Cold/Heat Intolerance
____Increased Thirst

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 authorized this office to release any information including diagnoses 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 authorized 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_____

Guardian's Signature _____ Date_____