

PLEASE PROVIDE US WITH A COPY OF THE ACCIDENT REPORT ON YOUR NEXT VISIT.

## AUTOMOBILE ACCIDENT HISTORY

PLEASE PRINT:

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ TIME: \_\_\_\_\_  AM  PM

DRIVER OF VEHICLE: \_\_\_\_\_ WHERE WERE YOU SEATED? \_\_\_\_\_

VEHICLE'S OWNER: \_\_\_\_\_ YEAR AND MODEL OF VEHICLE YOU WERE IN: \_\_\_\_\_

YEAR AND MODEL OF THE OTHER VEHICLE(S) IN THE COLLISION: \_\_\_\_\_

NUMBER OF VEHICLES IN THE COLLISION:  1  2  3  OTHER: \_\_\_\_\_

WHAT WAS THE APPROXIMATE DAMAGE DONE TO THE VEHICLE YOU WERE IN? \$ \_\_\_\_\_

WHERE DID THE ACCIDENT OCCUR? \_\_\_\_\_

VISIBILITY AT THE TIME OF ACCIDENT:  POOR  FAIR  GOOD

ROAD CONDITIONS AT THE TIME OF THE ACCIDENT:  ICY  RAINY  WET  CLEAR  DARK

YOUR VEHICLE:  HIT ANOTHER VEHICLE  WAS HIT IN THE:  RIGHT SIDE  LEFT SIDE  REAR  FRONT

TYPE OF ACCIDENT:  HEAD-ON COLLISION  BROAD-SIDE COLLISION  REAR-END COLLISION

FRONT-IMPACT, REAR-ENDED VEHICLE IN FRONT  SINGLE VEHICLE COLLISION

OTHER (EXPLAIN): \_\_\_\_\_

WERE THE INTERNAL VEHICLE PARTS BROKEN?  YES  NO

IF YES:  WINDSHIELD  RIGHT PASSENGER WINDOW  LEFT PASSENGER WINDOW

STEERING WHEEL  FRONT SEAT BACK  REAR VIEW MIRROR  OTHER \_\_\_\_\_

### IMPACT/SEAT BELT/HEADREST/SPEED/HEAD/BODY POSITION

DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED TO YOU UPON IMPACT: \_\_\_\_\_

YES  NO DID YOU SEE THE ACCIDENT COMING? \_\_\_\_\_

YES  NO WERE YOU PRE-WARNED THAT THE ACCIDENT WAS ABOUT TO HAPPEN? \_\_\_\_\_

YES  NO DID YOU BRACE FOR THE IMPACT? \_\_\_\_\_

YES  NO DID YOU HAVE YOUR HANDS ON THE STEERING WHEEL AT IMPACT? \_\_\_\_\_

HEAD/BODY POSITION AT THE TIME OF IMPACT:

HEAD:  STRAIGHT  TURNED RIGHT  TURNED LEFT

BODY:  STRAIGHT  TURNED RIGHT  TURNED LEFT

AT THE TIME OF THE ACCIDENT, WHAT PARTS OF YOUR HEAD/BODY HIT WHAT PARTS OF THE INSIDE OF THE VEHICLE: \_\_\_\_\_

YES  NO WERE YOU WEARING GLASSES, A HAT, OR DENTURES? WHERE WERE THEY AFTER THE ACCIDENT? \_\_\_\_\_

YES  NO WERE SEAT BELTS WORN?  YES  NO WERE SHOULDER HARNESSES WORN? \_\_\_\_\_

YES  NO DOES YOUR VEHICLE HAVE AIR BAGS?  SINGLE  DUAL  OTHER \_\_\_\_\_

YES  NO DID YOUR AIR BAG RELEASE?  ONE  BOTH  OTHER \_\_\_\_\_

YES  NO DOES YOUR VEHICLE HAVE HEADRESTS? IF YES, WHAT WAS ITS POSITION COMPARED TO YOUR HEAD BEFORE THE ACCIDENT?

TOP OF HEADREST EVEN WITH  MIDDLE OF NECK  TOP OF HEAD  BOTTOM OF HEAD

DISTANCE FROM BACK OF HEAD TO FRONT OF HEAD REST (APPROXIMATE INCHES) \_\_\_\_\_

YES  NO WAS YOUR VEHICLE BRAKING? \_\_\_\_\_

YES  NO WAS YOUR VEHICLE MOVING AT THE TIME OF THE ACCIDENT?  SLOWING DOWN  SPEEDING UP  CONSTANT SPEED

WHAT WAS THE SPEED LIMIT ON THE ROAD YOU WERE TRAVELING? \_\_\_\_\_ MPH

HOW MANY PEOPLE WERE IN YOUR VEHICLE? \_\_\_\_\_

### ABILITY TO MOVE BODY

WHERE WERE YOU IN THE VEHICLE PRIOR TO THE ACCIDENT? \_\_\_\_\_

AFTER THE ACCIDENT? \_\_\_\_\_

AS A RESULT OF THE ACCIDENT, WERE YOU:

RENDERED UNCONSCIOUS  DAZED, SITUATION VAGUE  SHAKEN UP BUT COULD FUNCTION

YES  NO COULD YOU MOVE ALL PARTS OF YOUR BODY? IF NO, WHAT PARTS AND WHY NOT? \_\_\_\_\_

YES  NO WERE YOU ABLE TO GET OUT OF THE VEHICLE UNAIDED? IF NO, WHY NOT? \_\_\_\_\_

### SYMPTOMS FROM ACCIDENT

YES  NO DID YOU RECEIVE ANY BRUISES FROM THE SEATBELTS? IF SO, WHERE? \_\_\_\_\_

YES  NO DID YOU RECEIVE ANY OTHER BLEEDING CUTS OR BRUISES? IF CUT, WHERE? \_\_\_\_\_

IF BRUISES, WHERE? \_\_\_\_\_

PLEASE DESCRIBE HOW YOU FELT. PLEASE BE SPECIFIC.

IMMEDIATELY AFTER THE ACCIDENT: \_\_\_\_\_

LATER THAT  DAY  NIGHT: \_\_\_\_\_

THE NEXT DAY(S): \_\_\_\_\_

## GENERAL SYSTEMS UPDATE

CHECK SYMPTOMS THAT HAVE BECOME APPARENT SINCE THE ACCIDENT/INJURY:

- |   |  |   |  |
|---|--|---|--|
| 1. <input type="checkbox"/> NERVOUSNESS             | 11. <input type="checkbox"/> LOSS OF BALANCE       | 21. <input type="checkbox"/> SLEEPING TROUBLE | 32. <input type="checkbox"/> HEADACHE            |
| 2. <input type="checkbox"/> NECK PAIN/STIFFNESS     | 12. <input type="checkbox"/> LOSS OF SMELL         | 22. <input type="checkbox"/> TOE NUMBNESS     | 33. <input type="checkbox"/> FAINTING            |
| 3. <input type="checkbox"/> MIDBACK PAIN            | 13. <input type="checkbox"/> LOSS OF TASTE         | 23. <input type="checkbox"/> FINGER NUMBNESS  | 34. <input type="checkbox"/> ANXIETY             |
| 4. <input type="checkbox"/> LOW BACK PAIN           | 14. <input type="checkbox"/> LOSS OF MEMORY        | 24. <input type="checkbox"/> COLD HANDS       | 35. <input type="checkbox"/> SEIZURES            |
| 5. <input type="checkbox"/> EYES SENSITIVE TO LIGHT | 15. <input type="checkbox"/> PINS & NEEDLES - ARMS | 25. <input type="checkbox"/> COLD FEET        | 36. <input type="checkbox"/> VISUAL DISTURBANCES |
| 6. <input type="checkbox"/> PAIN BEHIND EYES        | 16. <input type="checkbox"/> PINS & NEEDLES - LEGS | 26. <input type="checkbox"/> CHEST PAIN       | 37. <input type="checkbox"/> FORGETFULNESS       |
| 7. <input type="checkbox"/> DIZZINESS               | 17. <input type="checkbox"/> SHORTNESS OF BREATH   | 27. <input type="checkbox"/> CONSTIPATION     | 38. <input type="checkbox"/> BLURRED VISION      |
| 8. <input type="checkbox"/> COLD SWEATS             | 18. <input type="checkbox"/> HEAD SEEMS TOO HEAVY  | 28. <input type="checkbox"/> DIARRHEA         | 39. <input type="checkbox"/> DOUBLE VISION       |
| 9. <input type="checkbox"/> FACE FLUSHED            | 19. <input type="checkbox"/> IRRITABILITY          | 29. <input type="checkbox"/> FATIGUE          | 40. <input type="checkbox"/> CONFUSED            |
| 10. <input type="checkbox"/> RINGING/BUZZING EARS   | 20. <input type="checkbox"/> DEPRESSION            | 30. <input type="checkbox"/> TENSION          | 41. <input type="checkbox"/> DISORIENTED         |
|   |  | 31. <input type="checkbox"/> FEVER            | 42. <input type="checkbox"/> OTHER _____         |

## WORK STATUS HISTORY

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
 YES  NO HAVE YOU MISSED TIME FROM WORK? IF NO, WHO TOLD YOU TO RETURN TO WORK? \_\_\_\_\_  
IF YES,  OFF WORK FULL-TIME DATES: \_\_\_\_\_  
 OFF WORK PART-TIME DATES: \_\_\_\_\_  
 UNABLE TO RETURN TO WORK SINCE ACCIDENT.  
WHAT TYPE OF PHYSICAL ACTIVITY IS REQUIRED AT WORK? \_\_\_\_\_  
 YES  NO IS THERE ALTERNATIVE WORK AVAILABLE? \_\_\_\_\_

## FIRST DOCTOR/HOSPITAL/CLINIC

YES  NO DID YOU SEEK MEDICAL HELP IMMEDIATELY AFTER THE ACCIDENT? IF YES, HOW DID YOU GET THERE?  
 SOMEONE ELSE DROVE ME  DROVE OWN VEHICLE  POLICE  AMBULANCE  
DOCTOR/HOSPITAL/CLINIC: \_\_\_\_\_ DATE OF FIRST VISIT: \_\_\_\_\_  
 YES  NO WERE YOU EXAMINED?  YES  NO WERE X-RAYS TAKEN?  
WHAT DIAGNOSIS DID THE DOCTOR GIVE YOU? \_\_\_\_\_  
 YES  NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE? \_\_\_\_\_  
WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT? \_\_\_\_\_  
DATE OF LAST TREATMENT: \_\_\_\_\_  
 YES  NO DID THE DOCTOR REFER YOU TO ANOTHER HEALTH PROFESSIONAL? IF YES, TO WHO AND FOR WHAT? \_\_\_\_\_  
 YES  NO DID YOU FOLLOW THE DOCTOR'S RECOMMENDATION? IF NO, WHY NOT? \_\_\_\_\_

## SECOND DOCTOR/CLINIC

DOCTOR/CLINIC: \_\_\_\_\_ DATE OF FIRST VISIT: \_\_\_\_\_  
 YES  NO WERE YOU EXAMINED?  YES  NO WERE X-RAYS TAKEN?  
 YES  NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE? \_\_\_\_\_  
WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT? \_\_\_\_\_  
DATE OF LAST TREATMENT: \_\_\_\_\_

## PRIOR SIMILAR SYMPTOMS

YES  NO DID YOU HAVE ANY PHYSICAL COMPLICATIONS JUST BEFORE THE ACCIDENT? IF YES, PLEASE DESCRIBE IN DETAIL: \_\_\_\_\_  
 YES  NO PRIOR TO THIS ACCIDENT, HAVE YOU EVER HAD SIMILAR SYMPTOMS? IF YES, PLEASE EXPLAIN (FALLS, INJURIES, ETC.) \_\_\_\_\_  
 YES  NO HAVE YOU BEEN IN ACCIDENTS PRIOR TO THIS ONE? IF YES, WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_  
HOW WAS IT TREATED? \_\_\_\_\_ RESULT OF TREATMENT: \_\_\_\_\_  
 YES  NO ARE YOU NOW BEING TREATED?  
 YES  NO DO YOU HAVE ANY CONGENITAL (BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM? IF YES, PLEASE DESCRIBE: \_\_\_\_\_

ADDITIONAL COMMENTS