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Patient First
Chiropractic & Physical Therapy

AUTOMOBILE ACCIDENT PAPERWORK:

Name: _____ Date: _____ / _____ / _____

In your own words described what happened: _____

_____

_____

Date of the accident? ____ / ____ / _____ Location of accident: _____

What was your position? (circle one): driver / middle front / passenger / middle back / left rear / right rear

What was the speed of your vehicle? _____ m.p.h. What was the speed of the other vehicle? _____ m.p.h.

Damage to the vehicle you were riding in? (circle one): mild / moderate / extensive / totaled

What was the weather condition? (circle all that apply): snowing / raining / windy / foggy / clear

Who hit who/what? (circle one): I hit the other vehicle / the other vehicle hit me,

I hit the other object – what was the object? _____

What was the point of impact? (circle one): front / rear / left front / left rear / left side / right front / right rear / right side

Were you wearing a seatbelt? Yes / No Were you using the shoulder harness? Yes / No

Does the vehicle have an airbag? Yes / No Was the airbag deployed? Yes / No

Did you strike anything on the vehicle? Yes / No.

If yes, what part of the car did you hit? (circle all that apply): wheel, windshield, armrest, dashboard, side door, side window, airbag. What part of your body hit? _____

Did you see the accident coming? Yes / No.

Does the vehicle have headrests? Yes / No

What was the headrest position? (circle one): even with top of head, even with bottom of head, middle of neck

Were you braced for impact? Yes / No Were you dazed after the accident? Yes / No

Did you lose consciousness? Yes / No If yes for how long? _____

What was the direction of your head? (circle one): facing straight forward / looking to the right / looking to the left

Was your head injured? Yes / No Any other body part injured? _____

Immediately after the accident did you experience any pain? (circle all that apply):

Headaches / neck pain / lower back pain? Other?: _____

Did you go to the hospital? Yes / No If yes, which one? _____

How did you get to the hospital? (circle one): ambulance / I drove myself / someone drove me / police.

What tests were done at the hospital (circle all that apply): x-ray / MRI / CT / lab work

Did you visit any other doctors concerning this accident before coming here? Yes / No

Dr. _____ What tests were performed? _____

Is your condition (circle one): improving / getting worse / staying the same

Have you lost time from work due to this accident? Yes / No If yes for how long? ______________________

Can you perform physical work activities? Yes / No

If no, why not? (circle all that apply): Pain, weakness, stress, other______________________

Are you having problems (check all that apply):

___ seeing	___ tasting	___ smelling	___ eating	___ hearing	___ bathing	___ grooming
___ dressing	___ reading	___ typing	___ writing	___ grasping	___ holding	___ pinching
___ standing	___ leaning	___ walking	___ stooping	___ squatting	___ climbing	___ kneeling
___ bending	___ twisting	___ carrying	___ lifting	___ pushing	___ pulling	___ reaching
___ sitting	___ driving	___ riding in car	___ air travel	___ sports	___ exercising	___ loss of sexual drive
___ reclining	___ restful sleeping	___insomnia	___ using the toilet		___ loss of concentration	
___ nervous	___ irritable	___ change in personality		___ tactile feeling		

Additional activities of daily living that you are having problems with:______________________

Can you go to sleep without problems? Yes / No Do you awaken because of pain? Yes / No If yes where? ______

Have you had sleep problems before? Yes / No

What is your occupation? ______________________ Do you perform regular or light duty? ______________________

Are the injuries from this accident a financial burden for your and your family? Yes / No If yes explain how __________

Have you been in an accident before? Yes / No If yes what year? __________

Who treated you? __________________ Any residual problems? ______________

Past Medical History:____

Past Surgical History;____

Family: ____

Current Medications: ____

Allergies: ____

Social History.

Marital Status (circle one): married / single / widowed / divorced / separated

Do you have children? Yes / No Are you pregnant? Yes / No / Does not apply

Do you smoke? Yes / No. If yes how many packs per day? ____________________

Do you drink alcohol? Yes / No. If yes, how many drinks per week? ____________

Do you drink coffee? Yes / No. If yes, how many cups per day? ______________

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I understand and agree that all services rendered time are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care/treatment, any fees for services rendered me will be immediately due and payable

Patients Signature: __________________________ S.S. #: _______ - _____ - _______ Date: ____ / ____ / _______
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Complaint 1: ____

How would you rate your pain? 0 = no pain, 10 = worst pain imaginable (circle one)

0 1 2 3 4 5 6 7 8 9 10

Did this complaint come on gradually or immediately? ________________

Is you condition getting (circle one): better / worse / same.

Intensity (circle one): minimal, slight, moderate, severe

How often do you experience the pain/discomfort? (circle one):

comes and goes /some of the time / most of the time / all of the time

How would you describe the feeling (circle all that apply):

dull sharp aching shooting spasm throbbing burning

numbing tingling other:________________

Actions that effect this complaint: mark "A" for Aggravate, "R" for relieves, or leave blank

___ in the morning	___ in the afternoon	___ bending forward	___ bending back	___ bending left
___ bending right	___ twisting left	___ twisting right	___ coughing	___ sneezing
___ straining	___ standing	___ lifting	___ sitting	___ heat
___ cold	___ rest	___ lying down	___ medications	

Other actions that make your condition better or worse? ________________

Does your pain travel to other areas of your body? Head / neck / shoulder / arm / hand / hip / leg / foot

Also travels to: ____

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Complaint 2: ____

How would you rate your pain? 0 = no pain, 10 = worst pain imaginable (circle one)

0 1 2 3 4 5 6 7 8 9 10

Did this complaint come on gradually or immediately? ________________

Is you condition getting (circle one): better / worse / same.

Intensity (circle one): minimal / slight / moderate / severe

How often do you experience the pain/discomfort? (circle one):

comes and goes /some of the time / most of the time / all of the time

How would you describe the feeling (circle all that apply):

dull sharp aching shooting spasm throbbing burning

numbing tingling other:________________

Actions that effect this complaint: mark "A" for Aggravate, "R" for relieves, or leave blank

___ in the morning	___ in the afternoon	___ bending forward	___ bending back	___ bending left
___ bending right	___ twisting left	___ twisting right	___ coughing	___ sneezing
___ straining	___ standing	___ lifting	___ sitting	___ heat
___ cold	___ rest	___ lying down	___ medications	

Other actions that make your condition better or worse? ________________

Does your pain travel to other areas of your body? (circle): head / neck / shoulder / arm / hand / hip / leg / foot

Also travels to: ____
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Complaint 3: ______________________________

How would you rate your pain? 0 = no pain, 10 = worst pain imaginable (circle one)

0 1 2 3 4 5 6 7 8 9 10

Did this complaint come on gradually or immediately? ______________

Is you condition getting (circle one): better / worse / same.

Intensity (circle one): minimal, slight, moderate, severe

How often do you experience the pain/discomfort? (circle one):

comes and goes /some of the time / most of the time / all of the time

How would you describe the feeling (circle all that apply):

dull sharp aching shooting spasm throbbing burning

numbing tingling other:______________

Actions that effect this complaint: mark "A" for Aggravate, "R" for relieves, or leave blank

___ in the morning	___ in the afternoon	___ bending forward	___ bending back	___ bending left
___ bending right	___ twisting left	___ twisting right	___ coughing	___ sneezing
___ straining	___ standing	___ lifting	___ sitting	___ heat
___ cold	___ rest	___ lying down	___ medications	

Other actions that make your condition better or worse? ______________

Does your pain travel to other areas of your body? Head / neck / shoulder / arm / hand / hip / leg / foot

Also travels to: ______________________________

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Complaint 4: ______________________________

How would you rate your pain? 0 = no pain, 10 = worst pain imaginable (circle one)

0 1 2 3 4 5 6 7 8 9 10

Did this complaint come on gradually or immediately? ______________

Is you condition getting (circle one): better / worse / same.

Intensity (circle one): minimal / slight / moderate / severe

How often do you experience the pain/discomfort? (circle one):

comes and goes /some of the time / most of the time / all of the time

How would you describe the feeling (circle all that apply):

dull sharp aching shooting spasm throbbing burning

numbing tingling other:______________

Actions that effect this complaint: mark "A" for Aggravate, "R" for relieves, or leave blank

___ in the morning	___ in the afternoon	___ bending forward	___ bending back	___ bending left
___ bending right	___ twisting left	___ twisting right	___ coughing	___ sneezing
___ straining	___ standing	___ lifting	___ sitting	___ heat
___ cold	___ rest	___ lying down	___ medications	

Other actions that make your condition better or worse? ______________

Does your pain travel to other areas of your body? (circle): head / neck / shoulder / arm / hand / hip / leg / foot

Also travels to: ______________________________
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