Welcome to West Chiropractic and Wellness Automobile Accident Form

Patient Information (Please Print)

Name _____ Date_____
First MI Last

Address _____ City _____ State _____ Zip_____

Sex: ❒ Female ❒ Male Birth Date_____

Home # _____ Cell #_____ Work # _____

Do you prefer to receive calls at (mark all that apply) : ❒ Home ❒ Work ❒ Cell

Email address:_____

Are you: ❒ Minor ❒ Married ❒ Divorced ❒ Widowed ❒ Single ❒ Separated

Your Employer _____ Occupation_____

Person to contact in case of emergency _____ Phone # _____

Accident Details

Date of Accident:_____ Time of Accident:_____am / pm

Road conditions at the time of accident: WET DRY ICY Other:_____

Did the police come to the accident scene? YES NO Is there a report on file? YES NO

Did you go to the hospital? YES NO Did you get an X-Ray? YES NO What area? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

Did you suffer from any bleeding cuts and/or bruises? (explain)_____

Where were you seated in the vehicle? DRIVER PASSENGER L REAR MIDDLE REAR R REAR

Was your car stopped at the time of impact? YES NO If yes, was the driver's foot on the brake? YES NO

If no, then estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it: Slowing down? YES NO Gaining Speed? YES NO

Traveling at a steady rate of speed? YES NO

Was your head pointed straightforward at the time of the collision? YES NO

If no, how was it turned and how much? _____

Was your body pointed straight forward at the time of the collision? YES NO

If no, how was it turned?_____

Were you aware of the approaching collision prior to the impact, or were you surprised? AWARE SURPRISED

Were you wearing a seatbelt? YES NO If yes, was it a LAP SEAT BELT or a SHOULDER-LAP SEATBELT?

Did you receive any injury from the seat belt? YES NO If yes, describe:_____

On what part of the automobile did your following body parts hit?

Head hit _____ Chest hit_____

Right/Left shoulder hit _____ Right/Left arm hit _____

Right/Left hip hit _____ Right/Left leg hit_____

Right/Left knee hit_____ Other:_____

Was the other vehicle moving at the time of the collision? YES NO If yes, approx speed: _____

If the other vehicle was moving, was it: SLOWING DOWN GAINING SPEED STEADY SPEED

Symptoms

Did you lose consciousness (black out) upon impact? YES NO How long? _____

Did you become one of the following from the accident?

CONFUSED DISORIENTED LIGHTHEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN THE EARS

If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following:

DIFFICULT CONCENTRATING RESTLESSNESS SLEEPLESSNESS REDUCED TOLERANCE TO HEAT IRRITABLE

DIFFICULTY WITH MEMORY CHILLS REDUCED TOLERANCE TO ALCOHOL FORGETFULNESS

When did you first notice the symptoms? _____ Is this condition getting progressively worse? Y N

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❒ Sitting ❒ Standing ❒ Walking ❒ Bending

❒ Lying Down ❒ Other _____----------_____

Type of Pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting ❒ Burning ❒ Tingling

❒ Cramps ❒ Stiffness ❒ Swelling ❒ Other _____----------_____

Rate of severity of your pain. (1, mild pain to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? ❒ Medication ❒ Surgery ❒ Physical Therapy

❒ Other _____

Name address of other doctor(s) who have treated you for your condition: _____

_____

Health History

Check only those conditions which are applicable:

❒ AIDS/HIV	❒ Cataracts	❒ Hepatitis	❒ Osteoporosis	❒ Suicide Attempt
❒ Alcoholism	❒ Chemical Dependency	❒ Hernia	❒ Pacemaker	❒ Thyroid Problems
❒ Allergy Shots	❒ Chicken Pox	❒ Herniated Disc	❒ Parkinson's Disease	❒ Tonsillitis
❒ Anemia	❒ Depression	❒ Herpes	❒ Pinched Nerve	❒ Tuberculosis
❒ Anorexia	❒ Diabetes	❒ High Cholesterol	❒ Pneumonia	❒ Tumors, Growths
❒ Appendicitis	❒ Emphysema	❒ Kidney Disease	❒ Polio	❒ Typhoid Fever
❒ Arthritis	❒ Epilepsy	❒ Liver Disease	❒ Prostate Problems	❒ Ulcers
❒ Asthma	❒ Fractures	❒ Measles	❒ Prosthesis	❒ Vaginal Infection
❒ Bleeding Disorders	❒ Glaucoma	❒ Migraine Headaches	❒ Psychiatric Care	❒ Venereal Disease
❒ Breast Lump	❒ Goiter	❒ Miscarriage	❒ Rheumatoid Arthritis	❒ Whooping Cough
❒ Bronchitis	❒ Gonorrhea	❒ Mononucleosis	❒ Rheumatic Fever	❒ Other _____
❒ Bulimia	❒ Gout	❒ Multiple Sclerosis	❒ Scarlet Fever	_____
❒ Cancer	❒ Heart Disease	❒ Mumps	❒ Stroke	_____

Dates of last exams_____

(Women) Are you pregnant? ❒ Yes ❒ No Taking birth control pills? ❒ Yes ❒ No

List any types of surgeries which you have had and the dates which they occurred: _____

_____

_____

Please list all medications you are currently taking: _____

Allergies:_____

Daily Habits

What type of exercise do you perform on a daily basis? ❒ None ❒ Moderate ❒ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work, etc.)

_____

What vitamins do you currently take?

_____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? ❒ Yes ❒ No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis 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 authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic 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.

X _____

SIGNATURE OF PATIENT (or parent if a minor) DATE