

NEW PATIENT MOTOR VEHICLE COLLISION INFORMATION

Date: _____

First Name _____ Middle Initial _____ Last Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ May We Send You Our Practice Newsletter? _____

Date of Birth: ____/____/____ Age: _____

Emergency Contact : _____ Contact Phone: _____

Family Physician: _____ Phone Number: _____

How did you hear about our office? _____

1. What are the complaints for which you are seeking treatment?

2. If you have pain, please describe and give location: _____

3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

Patient name _____ Date _____

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. Do you consider this problem to be severe?

- Yes Yes, at times No

12. What aggravates your problem?

13. What concerns you the most about your problem; what does it prevent you from doing?

General Information:

Marital status _____ Children? _____ Do you smoke? _____ Yes _____ No

Do you drink alcohol? _____ Never _____ Light _____ Moderate _____ Heavy

At the time of the collision where were you employed? _____

Where are you currently employed? _____

Medical History:

Have you ever had any surgery? _____ Yes _____ No

If yes, please list with year: _____

Have you ever had any broken bones? _____ Yes _____ No

If yes, explain: _____

Have you ever had any serious illnesses? _____ Yes _____ No

If yes, explain: _____

Have you ever had any work comp injuries? _____ Yes _____ No

If yes, explain: _____

Have you ever had any previous motor vehicle collisions? _____ Yes _____ No

If yes, explain: _____

Patient name _____ Date _____

Have you ever had any sports or other injuries to the head, neck, or back? ____ Yes ____ No

If yes, explain: _____

Have you ever had your current pain/conditions in the past? ____ Yes ____ No

If yes, explain: _____

Have you ever been treated by a chiropractor? ____ Yes ____ No

If so, explain when/why: _____

Do you have any current health problems? ____ Yes ____ No

If so, explain when/why: _____

Are you taking any medications? ____ Yes ____ No

If so, explain what/why: _____

Injury History:

Date of Collision _____ Time of Collision _____ AM/PM

In your own words, describe the accident:

How many vehicles were involved in the accident? _____

What was the estimated damage to the vehicle you were in? _____

What was the damage to the other vehicle(s)? None Minimal Moderate Major

Type of Accident: (circle one) -Your vehicle was rear-ended -Your vehicle rear-ended another vehicle

-Hit on driver's side -Hit on passenger side -Other _____

Did your vehicle hit anything after the accident? _____

Where were you sitting in the vehicle during the accident? Driver Front passenger Rear

Who was driving? _____

Did you know the accident was coming? Yes No

What type of vehicle were you in? (Make/Model) _____

What type of vehicle impacted yours? (Make/Model) _____

Patient name _____ Date _____

At the time of the impact, how fast was your vehicle moving? _____

Stopped Slowing Accelerating

At the time of impact, what was the other vehicle doing? Stopped Slowing Accelerating

During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- Other _____
- spun around
- spun around and hit a stationary object
- hit a stationary object

Did you lose consciousness during the accident? Yes No
If yes, for how long? _____

What was your *head* position at the time of impact? (circle)

rotated left straight ahead rotated right

What was your *body* position at the time of impact? (circle)

Forward lean rotated left straight ahead rotated right

How were your hands positioned during the accident? One on wheel Two on wheel Other _____

Did you strike any parts of the vehicle? Yes No

If yes, describe _____

What kind of headrest was in your vehicle? Adjustable Non-movable No headrest

How was the headrest positioned? Up Down

If adjustable, was the position altered by the crash? _____

Was the seat back adjustment altered by the crash? Yes No

Was the seat broken? Yes No

Did you have your seatbelt on during the accident? Yes No

If yes, was the shoulder harness worn? Yes No

Did you slide out of your seatbelt during the accident? Yes No

Were you wearing a hat or glasses? Yes No

If yes, were they still on after the crash? Yes No

Did the air bag deploy? Yes No

If yes, were you struck? Yes No

Was the crash on-the-job? Yes No

What were the road conditions? Dry Damp Wet Snow Other _____

Patient name _____ Date _____

Were the police on-scene? Yes No
If yes, was a report made? Yes No

What was damaged in your vehicle? (Circle all that apply)

- windshield
- steering wheel
- dashboard
- seat frame
- side window L/R
- rear bumper
- front bumper
- trunk
- front door L/R
- rear window
- mirror
- back door L/R
- back right door
- completely totalled
- Other _____

Choose the items that dented inward

- floorboards
- side door
- dashboard

Choose the doors that would not open as a result of the accident

- front left
- front right
- rear left
- rear right

Did you seek medical attention immediately after the accident? Yes No
If yes, where did you go? _____
How did you get there? _____
Were you hospitalized overnight? _____

Circle what you were prescribed at the hospital or clinic

- pain medication
- muscle relaxers
- neck brace
- Other _____

Did you receive any stitches for any cuts at the hospital or clinic? _____

Were x rays or MRIs taken at the hospital? If yes, which area was taken? _____

Treatment History:

Have you seen any other doctors since the accident? Yes No
Name: _____ Specialty: _____
Date First Seen: _____ Currently Treating? Yes No
Were any tests done? Yes No If yes, list: _____
Did you receive treatment? Yes No
If yes, what kind of treatment? _____
What benefits did you receive from the treatment? _____
Last date of treatment? _____
Were you given any disability? Yes No If yes, describe: _____

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Additional Doctors: _____