Patient ID: _____

AUTO ACCIDENT HISTORY RECORD

Welcome to **Focused On You Chiropractic**. We are glad that you have chosen our clinic. We appreciate the time you will spend completing our forms. Our doctors of chiropractic will use the information you provide, along with a consultation and a thorough spinal exam to determine how we can best help you. Due to the nature of your accident you are required to complete the Auto Accident History Record and the Confidential Patient Health Record.

Please Print and Fill-in/Circle Answers

In order to serve you better, the following information is required:

PERSONAL INFORMATION:

Today's Date: _____ Patient Name: _____

PERSONAL INJURY HISTORY:

Date of Accident: _____ Time: _____ **AM PM**

Name of Driver of Vehicle: _____

Name of Owner of Vehicle: _____

Year of Vehicle: _____ Make of Vehicle: _____

Model of Vehicle: _____

Year of Other Vehicle: _____ Make of Other Vehicle: _____

Model of Other Vehicle: _____

What was the approximate damage done to your vehicle? _____

Visibility at the time of the accident:

Poor Fair Good Other: _____

Road conditions at the time of the accident:

Icy Rainy Wet Clear Dark Other: _____

Type of Accident:

Head-on Broad-side Front Impact Front Rear-end Rear Impact Non-Collision

Where was your car struck (Mark with an "X")? _____

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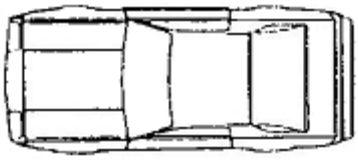

Where were you sitting (Mark with an "O")? _____

In your own words, please describe the accident: _____

_____

_____

At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____

_____

Did you see the accident coming? **Yes No**

Did you brace for the impact? **Yes No**

Were you wearing a seatbelt? **Yes No**

Were you wearing a shoulder harness? **Yes No**

How was the shoulder harness adjusted? **Snug Loose**

Were you wearing a hat? **Yes No**

Were you wearing glasses? **Yes No**

Does your car have headrests? **Yes No**

If yes, what was the position of those headrests compared to your head before the accident?

- ☐ **Top of headrest even with <u>bottom</u> of head**
- ☐ **Top of headrest even with <u>top</u> of head**
- ☐ **Top of headrest even with <u>middle</u> of neck**

Was your car braking at the time of the accident? **Yes No**

Was your car moving at the time of the accident? **Yes No**

If yes, how fast would you estimate you were going? _____**mph**

How fast would you estimate the other car was going? _____**mph**

What was your head/body position at the time of the impact?

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- ☐ **Head turned right/left**
- ☐ **Head looking back**
- ☐ **Head straight forward**
- ☐ **Body straight in sitting position**
- ☐ **Body rotated right/left**
- ☐ **Other:** _____

As a result of the accident were you:

- ☐ **Rendered unconscious**
- ☐ **Dazed, circumstances vague**
- ☐ **In shock**
- ☐ **Other:** _____

Were you able to move all parts of your body following the accident? **Yes** **No**

If no, what parts couldn't you move following the accident and why? _____

_____

Were you able to get out of the car and walk unaided? **Yes** **No**

If no, why not? _____

Did you get any bleeding cuts? **Yes** **No**

If yes, where and please explain: _____

_____

Did you get any bruises? **Yes** **No**

If yes, where and please explain: _____

_____

Please describe how you felt immediately after the accident: _____

_____

Please describe how you felt later that day: _____

_____

Please describe how you felt the next day: _____

_____

Check symptoms apparent since the accident:

- ☐ **Headache**
- ☐ **Eyes Light Sensitive**
- ☐ **Fainting**
- ☐ **Numbness in Toes**
- ☐ **Loss of Memory**
- ☐ **Neck Pain/Stiffness**
- ☐ **Pain Behind Eyes**
- ☐ **Sleeping Problems**
- ☐ **Loss of Smell**
- ☐ **Fatigue**
- ☐ **Mid Back Pain**
- ☐ **Dizziness** **(cont. next page)**
- ☐ **Numbness in Fingers**
- ☐ **Loss of Taste**
- ☐ **Shortness of Breath**

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☐ **Irritability**	☐ **Depression**	☐ **Ringing/Buzzing**
☐ **Loss of Balance**	☐ **Tension**	☐ **Cold Hands**
☐ **Cold Feet**	☐ **Diarrhea**	☐ **Constipation**
☐ **Chest Pain**	☐ **Nervousness**	☐ **Cold Sweats**
☐ **Anxious**	☐ **Facial Pain**	☐ **Clicking/Popping in Jaw**
☐ **Low Back Pain**	☐ **Other:** _____	

_____

Have you missed time from work? **Yes** **No**

If yes, full-time off work from _____ to _____

If yes, part-time off work from _____ to _____

Did you seek medical help immediately after the accident? **Yes** **No**

If yes, how did you get there?

Ambulance **Police** **Someone Else Drove** **Drove Myself** **Other:** _____

Doctor's Name: _____

Name of Facility: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone number: _____

Were you examined? **Yes** **No**

Were X-rays taken? **Yes** **No**

Did you receive treatment? **Yes** **No**

What type of treatment did you receive?

- ☐ **Medications, please list:** _____
- ☐ **Braces**
- ☐ **Collars**
- ☐ **Other:** _____

What benefits did you receive from the treatment? _____

_____

Since the accident have you seen anyone else for this? **Yes** **No**

If yes, Doctor's Name: _____ Dates: _____

Name of Facility: _____

Patient ID: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone number: _____

Were you examined? **Yes** **No** Were X-rays taken? **Yes** **No**

Did you receive treatment? **Yes** **No**

What type of treatment did you receive?

- **Medications, please list:** _____
- **Braces**
- **Collars**
- **Other:** _____

Have you seen anyone else for treatment? **Yes** **No**

If yes, Doctor's Name: _____ Dates: _____

Name of Facility: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone number: _____

Were you examined? **Yes** **No** Were X-rays taken? **Yes** **No**

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Patient ID: _____

Are you working with an insurance agent? **Yes** **No**

If yes, whom? _____

Claim #: _____ Address: _____

E-mail: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

□ I authorize Focused On You Chiropractic P.L.L.C to send any medical records and any other necessary communications with the person, or persons, listed above.

Signature: _____ Date: _____

Are you working with an attorney? **Yes** **No**

If yes, whom? _____

Address: _____

E-mail: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

□ I authorize Focused On You Chiropractic P.L.L.C to send any medical records and any other necessary communications with the person, or persons, listed above.

Signature: _____ Date: _____