PRICEPERFORMANCE CHIROPRACTIC

Motor Vehicle Accident History

PERSONAL INFORMATION

Patient Name: (Last, First, MI)			Date:
Address:		City:	State/Zip Code:
Home Phone:	Cell Phone:	Email Address:	
Work Phone:		Emergency Contact and Phone:	
Social Security Number:	Date of Birth:	Age:	Gender:
Employer Name:	Employer Address:		Employer Phone:

ACCIDENT INFORMATION

Date of accident:	Time of accident:	Where were you located in the vehicle at the time of the accident? ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat
Number of people in the car:	Names of people in the car with you:	
What direction was your car headed? ☐ North ☐ South ☐ East ☐ West		Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side
Were you knocked unconscious? ☐ Yes ☐ No		Did you hit your head? ☐ Yes ☐ No
Where were you taken after the accident?		By ambulance: ☐ Yes ☐ No
Immediately after the collision did you feel: ☐ Frightened ☐ Stunned ☐ Pain ☐ Dizzy ☐ Disoriented ☐ Confused ☐ Unconscious		Did the airbag deploy? ☐ Yes ☐ No
Speed the vehicle(s) were traveling?		Were you wearing a seatbelt? ☐ Yes ☐ No
Since the injury, are your symptoms: ☐ Improving		☐ Getting worse ☐ Getting better
Were the police on the scene? ☐ Yes ☐ No	Was a report filed? ☐ Yes ☐ No	Do you have a copy? ☐ Yes ☐ No
Have you been treated by any other doctors for this accident? ☐ Yes ☐ No		What treatments were given?
Have you lost time from work? ☐ Yes ☐ No	Date you left work:	Date you returned to work:
Have you been involved in an accident in the past? ☐ Yes ☐ No	If yes, please describe:	
Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No	If yes, please describe:	
Do you have any activity restrictions as a result of this injury? ☐ Yes ☐ No	If yes, please describe:	

SINCE THE ACCIDENT HAVE YOU EXPERIENCED:

Headaches: ☐ constant ☐ comes & goes ☐ dull ☐ ache ☐ moderate ☐ sharp ☐ shooting ☐ numbness
Pain on a scale of 1-10, 10 being the worst 1 2 3 4 5 6 7 8 9 10

Neck: ☐ constant ☐ comes & goes ☐ dull ☐ ache ☐ moderate ☐ sharp ☐ shooting ☐ numbness ☐ burn ☐ tingle
Pain on a scale of 1-10, 10 being the worst 1 2 3 4 5 6 7 8 9 10
Pain radiating down the arms: ☐ Yes ☐ No

Mid-back: ☐ constant ☐ comes & goes ☐ dull ☐ ache ☐ moderate ☐ sharp ☐ shooting ☐ numbness ☐ burn ☐ tingle
Pain on a scale of 1-10, 10 being the worst 1 2 3 4 5 6 7 8 9 10

Low-back: ☐ constant ☐ comes & goes ☐ dull ☐ ache ☐ moderate ☐ sharp ☐ shooting ☐ numbness ☐ burn ☐ tingle
Pain on a scale of 1-10, 10 being the worst 1 2 3 4 5 6 7 8 9 10
Pain radiating down the arms: ☐ Yes ☐ No

Shoulder/knee/other: _____ ☐ constant ☐ comes & goes ☐ dull ☐ ache ☐ moderate ☐ sharp ☐ shooting
Pain on a scale of 1-10, 10 being the worst ☐ numbness ☐ burn ☐ tingle
1 2 3 4 5 6 7 8 9 10

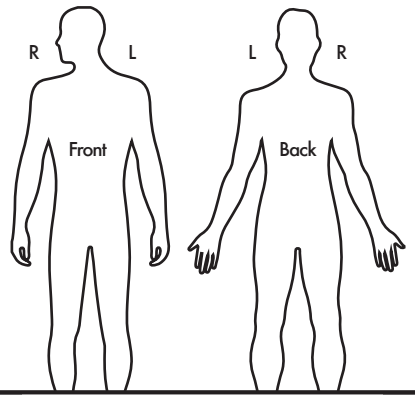
YOUR INSURANCE INFORMATION	THEIR INSURANCE INFORMATION
Auto insurance company name:	Auto insurance company name:
Adjuster name:	Adjuster name:
Adjuster phone number:	Adjuster phone number:
Policy number: Claim number:	Policy number: Claim number:

INSTRUCTIONS: CHECK (☐) ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.

- ☐ headache
- ☐ neck pain
- ☐ neck stiffness
- ☐ sleeping problems
- ☐ back pain
- ☐ nervousness
- ☐ tension
- ☐ irritability
- ☐ chest pain
- ☐ diarrhea
- ☐ constipation
- ☐ fever
- ☐ dizziness
- ☐ head seems heavy
- ☐ pins & needles in arms
- ☐ pins & needles in legs
- ☐ numbness in fingers
- ☐ numbness in toes
- ☐ shortness of breath
- ☐ fatigue
- ☐ depression
- ☐ feet feel cold
- ☐ hands feel cold
- ☐ cold sweats
- ☐ light bothers eyes
- ☐ loss of memory
- ☐ ears ring
- ☐ face flushed
- ☐ buzzing in ears
- ☐ loss of balance
- ☐ fainting
- ☐ loss of smell
- ☐ loss of taste
- ☐ upset stomach
- ☐ other _____

Please mark the area and type of pain on the drawings using the codes listed below:
N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness

Comments:



Please provide any other pertinent information you think we should know:

INSTRUCTIONS: Please check each of the diseases or conditions that you have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ severe or frequent headaches	☐ thyroid problems	☐ pain in arms/legs/ hands	☐ numbness
☐ heart surgery/ pacemaker	☐ sinus problems	☐ low blood pressure	☐ allergies
☐ lower back problems	☐ hepatitis	☐ rheumatic fever	☐ diabetes
☐ digestive problems	☐ difficulty breathing	☐ ulcers/colitis	☐ Cancer
☐ pain between shoulders	☐ kidney problems	☐ tuberculosis	☐ asthma
☐ congenital heart defect	☐ high blood pressure	☐ arthritis	☐ loss of sleep
☐ frequent neck pain	☐ chemotherapy	☐ shingles	☐ dizziness

Surgeries: (Please list all surgeries you have had)

Are you pregnant?	☐ Yes	☐ No
Sign below to indicate you are NOT pregnant in case x-rays are needed _____		
If yes, when is your due date?		
Where will you be birthing?		
Name of OB/Midwife:		
Are you nursing?	☐ Yes	☐ No
Are you taking birth control?	☐ Yes	☐ No
Do you:		
Experience painful periods?	☐ Yes	☐ No
Have irregular cycles?	☐ Yes	☐ No
Have breast implants?	☐ Yes	☐ No

Patient signature:	Date:

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