MOORE CHIROPRACTIC CENTER
707 Sunset Street
Denton, TX 76201
(940) 383-9399

Date_________________ **File #________**
Date of Accident_____________________

ACCIDENT HISTORY REPORT

Name ______________________________Address____________________________
City___________________________State______Zip__________Children__________
Date of Birth ____/____/____ Sex M___ F___ Marital Status M___ S___ D___ W___
Spouse__________________Do you smoke___Yes-How many per day______No____
Employer___________________________ Occupation__________________________
Home phone______________Work phone______________Cell phone_____________
Who may we contact in case of emergency? _________________________________
Phone________________________ Physician _________________________________

For Women Only: Date of last Period: ____/____/____ Are you pregnant? Y N

DESCRIPTION OF ACCIDENT (patient description)

____
____
____
____
____
____

___ Driver ___Passenger (front ___; Rear seat L___ R___) ___Pedestrian
___ Other____

Were you wearing a seat belt? ____YES ____NO
Were you wearing a shoulder belt? ____YES ____NO
Did your vehicle strike another vehicle or object? ____YES ____NO
- If yes describe:____

What was your head position?
___Looking straight ahead
___Looking left ___Deg.
___Looking right ___Deg.
___Looking up ___Deg.
___Looking down ___Deg.

Hands:
___One on the wheel (L or R)
___Both hands were on wheel
___NA-was not driving

Brake applied? ____YES ____NO

Aware of the impending collision? ____YES ____NO
Were you braced for the impact? ____YES ____NO
Did you strike any object inside your car? ____YES ____NO
Select the objects that you struck:
___Windshield ___Headrest ___Back of seat ___Seat broke
___Dashboard ___Steering wheel ___Door frame ___Side window
___Rearview mirror ___Rear window of pick-up
___Dazed cannot remember details ___Jarred or was thrown about

___Head ___Face ___Chest ___Neck ___Back

___Shoulder(s) L / R ___Arm(s) L / R ___Elbow(s) L / R

___Wrist(s) L /R ___Leg(s) L / R ___Knee(s) L / R

___Ankle(s) L / R ___Other_________________________________

Were you: ___Unconscious

___Cut or bleeding (describe)________________________

___Neither

Model and year of your vehicle: ____

Model and year of other vehicle(s): ____

Estimated property damage to your vehicle: $___________________________________

Estimated property damage to other vehicle(s):

$_________________________________

Did the air bag(s) deploy: ___YES ___NO ___NA

If applicable, indicate any pain or abnormal sensations you experienced following the accident, when and where:

___Immediately

___Felt no immediate pain

___Pain began several hours after accident

___Pain began shortly after accident

___Head pain (headache)

___Semi-conscious state ___Neck pain

___Mid back pain - (L/R) ___Low back pain

___Between the shoulder blades ___Upper extremity pain (L/R)

___Lower extremity pain (L/R) ___Saw stars

___Nausea ___Confusion/disorientation

___Numbness and/or tingling: Where__________________________________

PAIN SCALE

0 1 2 3 4 5 6 7 8 9 10

NO WORST

PAIN PAIN

Were the police called to the scene? ____YES ____NO
If yes, was a report made? ____YES ____NO

PLEASE PROVIDE A COPY OF THE POLICE REPORT TO THIS OFFICE AS SOON POSSIBLE!

Indicate the action you took immediately following the accident:
___Went home and took it easy
___Went about normal business
___Went to hospital
___Went home and later began to experience (neck/mid back/low back) pain
___Went home and later went to hospital
___I doctored myself thinking the pain would go away taking over the counter medication
___Went to medical doctor

HOSPITALIZATION

Indicate method of delivery to hospital:
___Ambulance ___Driven by spouse/relative/friend/employer
___I drove self
___Presbyterian Hospital of Denton ___Denton Regional Medical Center
___Other Hospital: ___________________________________City:__________________
Were you seen in the emergency room? ____YES ____NO
Were you admitted to the hospital? ____YES ____NO
Length of stay? ___________________________________
Name (if known) of attending physician?_______________________________________
Indicate any procedures performed at the hospital (including the emergency room):
___Examination ___Stitches
___X-Rays ___Physiotherapy (ex: ice, heat)
___Prescription ___Cervical collar
___Injection ___Wound dressed
___Complete bed rest ___MRI/CT
___Other____
Following your release from the hospital, where did you go?
___Returned home and took it easy.
___Returned home and went to bed.
___Returned home and returned to the emergency room after ___hours/days.
___Returned to work.

IF DR MOORE IS THE FIRST DOCTOR YOU HAVE SEEN FOR THIS ACCIDENT, SKIP TO PAST HISTORY

When did you first consult a physician?
___Same day ___Following day ___Within a few days Other: ___________________
Who was the first physician consulted? Dr.____________________________
___Family physician ___Neurologist ___Chiropractor
___Orthopedist ___Osteopath (D.O.) ___Internist
___Family Walk-In Clinic ___Other_______________________________

What was done?

___Examination ___Acupuncture
___X-Rays ___Collar/Support (belt/brace)
___ Prescription ___Traction
___Manipulation & P.T. ___P.T. only
___Manipulation only ___Other______________________________

Were you seen elsewhere for treatment? ___YES ___NO
-If yes, where did you receive these treatments?
____

Were you referred to any other physician or therapist? ___YES ___NO
-If yes, where did you receive these treatments? _____________________________
____

Were you referred for any special diagnostic tests or examinations?
___YES (explain) ___NO
___MRI ___CT ___EMG ___NCV ___SSEP
___Other____
____

How long were you under the care of this physician? _______________________________
Are you still under the doctor's care? ___YES ___NO
If no, when were you discharged?____
If yes, indicate the frequency of your visits to the doctor.____________________________
____

Other pertinent information: ____
____
____

PAST HISTORY

Have you ever had any previous accidents or injuries?
___No ___Yes - Give dates and details: ____
____
____
____

Have you ever been previously treated for neck and/or back problems? Please explain:
____
____
____

Have you been previously treated by a Doctor of Chiropractic? Please explain:
____
____
____

Past surgical history and/or conditions? Please explain:
____
____
____
____
____

Have you had any significant medical problems? (Diabetes; heart; lungs; high blood pressure; broken bones; etc.)____

____

Have any of your blood relatives had? (Diabetes, heart, lungs, high blood pressure, broken bones, etc.) ____

____

Did you enjoy good health prior to this accident?

___YES

___NO -

explain:____

____

List all medications presently taking:

____

____

____

DISABILITY

Have you lost any time from work since the accident?

___NO

___YES - number of days lost: _______

Are you still off from work?

___YES

___NO - Indicate the date you returned to work:____________________

Are you working at this time? ___YES ___NO

Are you working with any restrictions?

___NO ___YES - What are the restrictions:___________________________

____

Signature:______________________________________

Patient/Guardian 8/6/2008 ACCIDENT HX RPT (F)MCC FORMS

DOCTORS INITIALS:______