AUTO ACCIDENT HISTORY

SOUTHCENTER CHIROPRACTIC INC

Dr. Karm S. Virk

First Name: _____ Middle: _____Last: _____ Date: _____

INFORMATION ABOUT THE MOTOR VEHICLE ACCIDENT

Date of Accident: _____ Time: _____AM PM City where accident occurred: _____

Were you a: ☐ Driver ☐ Passenger ☐ Middle front seat ☐ Right front seat ☐ Left back seat
☐ Middle back seat ☐ Right back seat ☐ Pedestrian ☐ Motorcycle operator ☐ Motorcycle passenger

Where you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side ☐ Other _____

Were you aware of the collision prior to impact or did the impact catch you by surprise? ☐ Aware ☐ Unaware

Were you braced for the impact? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, How long? _____

What position was your head facing at the time of impact? ☐ Forward ☐ Left ☐ Right ☐ Other _____

Were you wearing a seatbelt with a shoulder harness? ☐ Yes ☐ No Lap belt only ☐ Yes ☐ No ☐ Don't know

Did an airbag deploy? ☐ No ☐ Yes, were you struck? ☐ No ☐ Yes, where? _____

Road conditions were: ☐ Dry ☐ Wet ☐ Ice ☐ Snow Visibility was: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Did police come to the accident scene? ☐ Yes ☐ No Was a report filled out? ☐ Yes ☐ No

Who was at fault? ☐ Driver of other vehicle ☐ Driver of my vehicle ☐ Myself ☐ Don't know

After the impact, where did you go? ☐ Home ☐ Work ☐ Hospital ☐ Private Doctor ☐ Other _____

How did you get there? ☐ Drove myself ☐ Someone Else Drove ☐ Ambulance ☐ Police ☐ Other _____

Please describe the accident (i.e., rear-ended, side-swiped, broad-sided, head-on): _____

_____

_____

_____

Did you receive any visible cuts or bruises as a result of the accident? ☐ Yes ☐ No If yes, where? _____

_____

Did you strike any parts of your body on the interior of the car? ☐ Yes ☐ No If yes, please explain. _____

_____

Your complaints included:

1._____ ☐ Immediately after impact ☐ Hours later ☐ Days later ☐ Other _____
2._____ ☐ Immediately after impact ☐ Hours later ☐ Days later ☐ Other _____
3._____ ☐ Immediately after impact ☐ Hours later ☐ Days later ☐ Other _____
4._____ ☐ Immediately after impact ☐ Hours later ☐ Days later ☐ Other _____
5._____ ☐ Immediately after impact ☐ Hours later ☐ Days later ☐ Other _____
6._____ ☐ Immediately after impact ☐ Hours later ☐ Days later ☐ Other _____

INFORMATION ABOUT THE VEHICLE YOU WERE IN

Year: _____ Make (Example-Honda): _____ Model (Example-Civic): _____

Was your vehicle: ☐ Slowing down ☐ Gaining speed ☐ Traveling at a steady speed ☐ Stopped in traffic
☐ Stopped at a "stop" sign ☐Parked ☐ Making a turn ☐ Changing lane ☐Other _____

Was your vehicle pushed forward from the impact? ☐ Yes ☐ No If yes, how much? _____

Did your vehicle strike any other objects after the crash? ☐ Yes ☐ No If yes, what? _____

Estimated damage to your vehicle: ☐ None ☐ Minimal ☐ Mild ☐ Moderate ☐ Considerable (totaled)

INFORMATION ABOUT OTHER VEHICLE(S) INVOLVED IN ACCIDENT

Year:_____ Make (Example-Honda): _____ Model (Example-Civic): _____

Was the other vehicle: ☐ Slowing down ☐ Gaining speed ☐ Traveling at a steady speed ☐ Don't know

If more than one other vehicle was involved please explain._____

_____

HOSPITAL EMERGENCY ROOM QUESTIONS

Were you taken to a hospital/emergency room after the accident? ☐ Yes ☐ No Date if not same day: _____

Name of the hospital/emergency? _____ In what city? _____
How did you get to the hospital/emergency? ☐ Ambulance ☐ Drove yourself ☐ Someone else drove you
Were x-rays taken? ☐ Yes ☐ No If yes, were x-rays taken while you were: ☐ Lying down ☐ Standing ☐ Sitting
What parts of your body were x-rayed? ☐ Neck ☐ Lower back ☐ Middle back ☐ Other: _____
Was lab work preformed? ☐ Yes ☐ No If yes, what type? _____
Treatment in emergency room: ☐ Ice/Heat ☐ Stitches ☐ Cervical collar ☐ physical therapy ☐ Other _____
Was Medication prescribed? ☐ Pain Killers ☐ Muscle relaxers ☐ Anti-inflammatory ☐ Other _____
Follow-up instructions: _____

_____

OTHER HEALTH CARE PROVIDERS SEEN FOR THIS ACCIDENT

1. Dr.: _____ Specialty: _____ Referred by: _____
Date first seen: _____ Date of last visit: _____ Number of visits to date: _____
Treatment: ☐ Medication ☐ physical therapy ☐ exam ☐ Other _____ Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No If yes, describe: _____
Special tests (X-ray, CAT scan, MRI): _____
Did treatment help? ☐ Yes ☐ No Referred to: _____

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Special tests (X-ray, CAT scan, MRI): _____
Did treatment help? ☐ Yes ☐ No Referred to: _____
Additional Notes: _____

_____

QUESTIONS ABOUT YOUR WORK & SOCIAL HISTORY

What is your occupation? _____
Employer at time of injury: _____ Employer's Phone #: _____
Employer's Address: _____
Is this accident an *on the job injury*? ☐ Yes ☐ No If yes, have you reported it to your employer? ☐ Yes ☐ No
Has an *on the job injury* claim been filed? ☐ Yes ☐ No If yes, what is the claim #: _____
Have you lost time from work as a result of this injury? ☐ Yes ☐ No If Yes, please list dates: _____
Date you returned to work or expect to return to work: _____
I am currently working: ☐ Full-time ☐ Part-time _____ hrs/wk ☐ Regular duty ☐ Light duty w/restrictions

Check those activities that are required of you at work

☐ Lifting	☐ Occasionally	☐ Frequently	☐ Continuously	Up to _____ lb.
☐ Carrying	☐ Occasionally	☐ Frequently	☐ Continuously	Up to _____ lb.
☐ Pushing	☐ Occasionally	☐ Frequently	☐ Continuously	Up to _____ lb.
☐ Pulling	☐ Occasionally	☐ Frequently	☐ Continuously	Up to _____ lb.
☐ Sitting	☐ Occasionally	☐ Frequently	☐ Continuously	
☐ Standing	☐ Occasionally	☐ Frequently	☐ Continuously	
☐ Walking	☐ Occasionally	☐ Frequently	☐ Continuously	
☐ Bending	☐ Occasionally	☐ Frequently	☐ Continuously	
☐ Reaching	☐ Occasionally	☐ Frequently	☐ Continuously	
☐ Twisting	☐ Occasionally	☐ Frequently	☐ Continuously	
☐ Computer work	☐ Occasionally	☐ Frequently	☐ Continuously	

Check those activities that cause a worsening of your accident related injuries

☐ Lifting	☐ Pulling	☐ Walking	☐ Twisting	☐ Computer work	☐ Interacting socially
☐ Carrying	☐ Sitting	☐ Bending	☐ Exercising	☐ Household chores	☐ Yard work
☐ Pushing	☐ Standing	☐ Reaching	☐ Other: _____		

SIGNATURE: _____ **DATE:** _____