IHC InjuryHealthCenter
Your Health...Our Mission

History of Auto Accident

Patient Name _____ DOB _____ Today's Date _____

Address _____ Date Of Accident _____

City _____ State _____ Zip _____ Time Of Accident _____

Social Security # _____ Phone Number _____ Emergency Contact # _____

Email _____

Name of Employer _____ Phone Number _____ Occupation _____

Nearest relative not living with you _____ Relationship _____ Phone Number _____

Family Physician _____ City _____ Phone Number _____

Auto Insurance _____ Claim # _____

Have you received treatment for this condition? ☐ Yes ☐ No If yes, please list facility below:

_____
Doctor/Hospital Date of Visit Results/Procedure

_____
Doctor/Hospital Date of Visit Results/Procedure

Have you ever been in an auto accident or a slip and fall accident? ☐ Yes ☐ No

If yes, how long ago? _____ Did you receive treatment? ☐ Yes ☐ No

Have you ever been given an impairment or been deemed disabled? ☐ Yes ☐ No When? _____

Have you ever had surgery? ☐ Yes ☐ No If yes, please list below:

_____
Doctor/Hospital Dates Procedure

_____
Doctor/Hospital Dates Procedure

Are you pregnant? ☐ Yes ☐ No Have you ever seen a chiropractor before? ☐ Yes ☐ No

_____
Chiropractor Phone Number Dates

Do you exercise: ☐ Never ☐ Occasionally ☐ Frequently ☐ Regularly

Use Alcohol: ☐ Yes ☐ No **Use Tobacco:** ☐ Yes ☐ No **If yes, what type?**

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Snuff ☐ Various Types ☐ Used to smoke

Since the motor vehicle accident, my symptoms have gotten:

☐ gotten much worse ☐ gotten worse ☐ improved ☐ gotten much better ☐ stayed the same

In the past, I have had: ☐ Same symptoms ☐ Similar symptoms ☐ No symptoms

Have you had any previous diagnostic testing done for this injury?

☐ Plain X-Rays ☐ MRI ☐ Cat Scan ☐ NCV ☐ Bone Scan ☐ Lab Work

☐ Video Fluoroscopy ☐ EMG ☐ Diagnostic Ultrasound ☐ Doppler Ultrasound ☐ No previous workup ☐ Other _____

Did you have any past treatment for this injury?

☐ Anti-inflammatories ☐ Muscle Relaxers ☐ Pain Meds ☐ Physical Therapy

☐ Surgery ☐ Exercise ☐ Bed Rest ☐ Ice/Heat

☐ Brace ☐ Manipulation ☐ None ☐ Other_____

If yes to any of the above, what is the name of the treating physician? _____

Have you ever undergone any surgical procedures? ☐ Yes ☐ No

If yes, please list surgical procedures: _____

At the time of the accident, how many people were with you? _____

Names of other occupants and where they were sitting in the vehicle:

1. _____ 3. _____

2. _____ 4. _____

Were other occupants injured? ☐ Yes ☐ No **If yes, please explain:** _____

Road conditions were: ☐ Dry ☐ Damp ☐ Wet

The road was made of: ☐ Concrete ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other_____

At the time of the accident, it was: ☐ Daylight ☐ Dawn ☐ Dark ☐ Dusk

Estimated cost to repair your vehicle: _$_____ **Other vehicle:** _$_____

After the accident the car was: ☐ totaled ☐ drivable ☐ not drivable

What state did accident occur in? _____

What city did accident occur in? _____

What street or intersection were you on when the accident occurred? _____

_____

What direction were you traveling in? _____

What type of impact was the auto accident? _____

Did your vehicle hit anything after the accident? If yes, please describe: _____

_____

Where were you in the car? ☐ driver ☐ front passenger ☐ left rear ☐ right rear ☐ front middle ☐ rear middle ☐ other_____

Were you aware of the impending collision? ☐ Yes ☐ No

Were you braced for the impact? ☐ Yes ☐ No

What type of vehicle were *you* driving/riding in?

☐ compact car	☐ mid size car	☐ full size car	☐ small SUV
☐ large SUV	☐ Van	☐ mini van	☐ station wagon
☐ small truck	☐ full size truck	☐ delivery truck	☐ tractor trailer
☐ camper	☐ bus	☐ other_____	

What type of vehicle was the other party driving?

☐ compact car	☐ mid size car	☐ full size car	☐ small SUV
☐ large SUV	☐ Van	☐ mini van	☐ station wagon
☐ small truck	☐ full size truck	☐ delivery truck	☐ tractor trailer
☐ camper	☐ bus	☐ other_____	

Your vehicle's speed was: ☐ stopped ☐ accelerating ☐ constant ☐ slowing

How fast was your vehicle traveling? _____ **miles per hour**

How fast was the other vehicle traveling? _____ **miles per hour**

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

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

Were you unconscious? ☐ Yes ☐ No **In a daze?** ☐ Yes ☐ No

Head Position: At the time of the accident, my head was looking:

☐ Straight ahead ☐ to the right ☐ to the left ☐ up ☐ down ☐ can't remember

Body Position: At the time of impact, by body was:

☐ Upright ☐ turned to the right ☐ turned to the left ☐ leaning forward ☐ can't remember

If you were the driver, which hands were on the steering wheel?

☐ Both ☐ Right ☐ Left ☐ Can't remember ☐ Other_____

Did your head hit anything during the accident? ☐ Yes ☐ No **If Yes, please describe:**

_____

Did your face hit anything during the accident? ☐ Yes ☐ No **If Yes, please describe:**

_____

Did your shoulders hit anything during the accident? ☐ Yes ☐ No **If Yes, please describe:** _____

Did your neck hit anything during the accident? ☐ Yes ☐ No **If Yes, please describe:**

_____

Did your chest hit anything during the accident? ☐ Yes ☐ No **If Yes, please describe:**

_____

Did your hips hit anything during the accident? ☐ Yes ☐ No **If Yes, please describe:**

_____

Did your knees hit anything during the accident? ☐ Yes ☐ No **If Yes, please describe:**

_____

Did your feet hit anything during the accident? ☐ Yes ☐ No **If Yes, please describe:**

_____

The head rests of the vehicle were:

☐ Part of the seat ☐ In the up position ☐ In the down position ☐ weren't any ☐ don't know

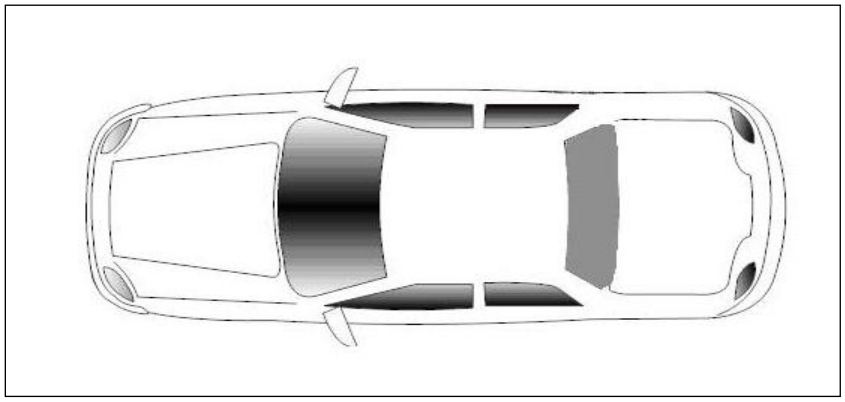
Where was the headrest positioned on your head? _____

During the motor vehicle accident:

Was your seatbelt on? ☐ Yes ☐ No Were your brakes on? ☐ Yes ☐ No

Did the airbag deploy? ☐ Yes ☐ No Did the seat break? ☐ Yes ☐ No

Please mark on vehicle below where your car was damaged:



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

☐ windshield	☐ side window	☐ trunk
☐ steering wheel	☐ rear window	☐ front left door
☐ dashboard	☐ rear bumper	☐ front right door
☐ seat frame	☐ front bumper	☐ back left door
☐ mirror	☐ knee bolster	☐ back right door
☐ completely totaled	☐ 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

After the accident, where did you go?

☐ Home	☐ Hospital	☐ Family Doctor	☐ Chiropractor
☐ School	☐ ER	☐ Work	☐ Other_____

If you went to the hospital, when? ☐ Immediately ☐ Next Day ☐ Other _____

How did you go to the hospital? ☐ Ambulance ☐ Private Transportation

Did the ambulance attendants place you in a neck collar? ☐ Yes ☐ No

Splints? ☐ Yes ☐ No **Brace?** ☐ Yes ☐ No

Name of Hospital: _____

Attended by Dr. _____

Were you admitted to the hospital? ☐ Yes ☐ No If yes, how long did you stay? _____

Were you prescribed and medications? (Check all that apply)

☐ pain medication ☐ muscle relaxors ☐ Other_____

Did you receive any stitches for any cuts at the hospital? ☐ Yes ☐ No

X-Ray: Were you x-rayed? ☐ Yes ☐ No If yes, what was the diagnosis? _____

_____

After the accident, I was feeling:

☐ Back Pain	☐ Disorientation	☐ Dizziness	☐ Headache	☐ Left arm numbness
☐ Left arm pain	☐ Left leg numbness	☐ Left leg pain	☐ Nausea	☐ Neck pain
☐ Right arm numbness	☐ Right arm pain	☐ Right leg numbness	☐ Right leg pain	☐ Other_____ _____

Were the police called to the scene? ☐ Yes ☐ No **Was a police report written?** ☐ Yes ☐ No

Do you have a copy of the report? ☐ Yes ☐ No If yes, please bring a copy of the report to our office.

Was a ticket given to you? ☐ Yes ☐ No Was a ticket given to the other driver? ☐ Yes ☐ No

Please check boxes below to describe your current symptoms and circle a corresponding number that indicates the pain severity.

Headaches: ☐ all of the time ☐ 75% of day ☐ 50% of day ☐ 25% of day

☐ Sharp ☐ Achy ☐ Numb ☐ Tingly ☐ Throbbing ☐ Burning
☐ Dull ☐ Sore ☐ Shooting ☐ Stiff ☐ Grinding ☐ Other

0 1 2 3 4 5 6 7 8 9 10
← No pain *Most severe pain can imagine →*

Neck: ☐ all of the time ☐ 75% of day ☐ 50% of day ☐ 25% of day

☐ Sharp ☐ Achy ☐ Numb ☐ Tingly ☐ Throbbing ☐ Burning
☐ Dull ☐ Sore ☐ Shooting ☐ Stiff ☐ Grinding ☐ Other

0 1 2 3 4 5 6 7 8 9 10
← No pain *Most severe pain can imagine →*

Mid-Back: ☐ all of the time ☐ 75% of day ☐ 50% of day ☐ 25% of day

☐ Sharp ☐ Achy ☐ Numb ☐ Tingly ☐ Throbbing ☐ Burning
☐ Dull ☐ Sore ☐ Shooting ☐ Stiff ☐ Grinding ☐ Other

0 1 2 3 4 5 6 7 8 9 10
← No pain *Most severe pain can imagine →*

Low Back: ☐ all of the time ☐ 75% of day ☐ 50% of day ☐ 25% of day

☐ Sharp ☐ Achy ☐ Numb ☐ Tingly ☐ Throbbing ☐ Burning
☐ Dull ☐ Sore ☐ Shooting ☐ Stiff ☐ Grinding ☐ Other

0 1 2 3 4 5 6 7 8 9 10
← No pain *Most severe pain can imagine →*

CHART CONTINUED ON NEXT PAGE....

Shoulders: ☐ left ☐ right ☐ both ☐ all of the time ☐ 75% of day ☐ 50% of day ☐ 25% of day

☐ Sharp ☐ Achy ☐ Numb ☐ Tingly ☐ Throbbing ☐ Burning
☐ Dull ☐ Sore ☐ Shooting ☐ Stiff ☐ Grinding ☐ Other

0 1 2 3 4 5 6 7 8 9 10
← No pain *Most severe pain can imagine →*

Arms: ☐ left ☐ right ☐ both ☐ all of the time ☐ 75% of day ☐ 50% of day ☐ 25% of day

☐ Sharp ☐ Achy ☐ Numb ☐ Tingly ☐ Throbbing ☐ Burning
☐ Dull ☐ Sore ☐ Shooting ☐ Stiff ☐ Grinding ☐ Other

0 1 2 3 4 5 6 7 8 9 10
← No pain *Most severe pain can imagine →*

Legs: ☐ left ☐ right ☐ both ☐ all of the time ☐ 75% of day ☐ 50% of day ☐ 25% of day

☐ Sharp ☐ Achy ☐ Numb ☐ Tingly ☐ Throbbing ☐ Burning
☐ Dull ☐ Sore ☐ Shooting ☐ Stiff ☐ Grinding ☐ Other

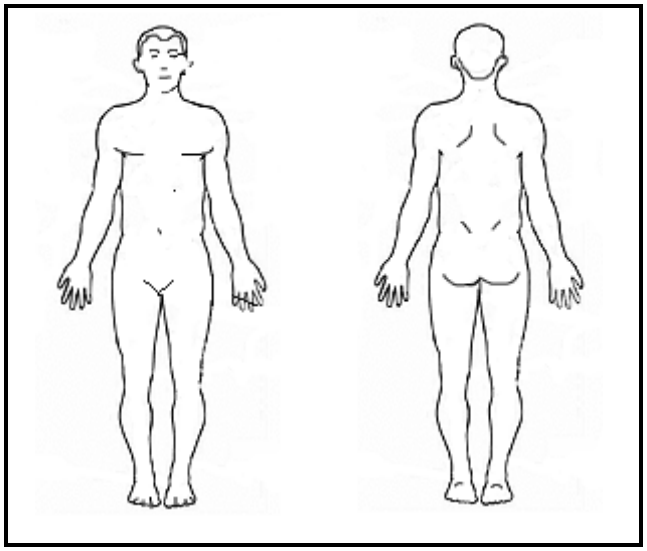
0 1 2 3 4 5 6 7 8 9 10
← No pain *Most severe pain can imagine →*

Knees: ☐ left ☐ right ☐ both ☐ all of the time ☐ 75% of day ☐ 50% of day ☐ 25% of day

☐ Sharp ☐ Achy ☐ Numb ☐ Tingly ☐ Throbbing ☐ Burning
☐ Dull ☐ Sore ☐ Shooting ☐ Stiff ☐ Grinding ☐ Other

0 1 2 3 4 5 6 7 8 9 10
← No pain *Most severe pain can imagine →*

Please mark on the body below where you are feeling your pain/discomfort:



Indicate which may make you feel better or worse by checking the appropriate answer below. Please check all that apply.

In the morning	___ Better ___ Worse	Standing	___ Better ___ Worse
In the evening	___ Better ___ Worse	Sitting	___ Better ___ Worse
In the afternoon	___ Better ___ Worse	Lying down	___ Better ___ Worse
While sleeping	___ Better ___ Worse	With movement	___ Better ___ Worse

CHART CONTINUED ON NEXT PAGE....

During menstrual cycle	___ Better	___ Worse	With rest	___ Better	___ Worse
In the winter	___ Better	___ Worse	With use	___ Better	___ Worse
In the spring	___ Better	___ Worse	While walking	___ Better	___ Worse
In the summer	___ Better	___ Worse	While running	___ Better	___ Worse
In the fall	___ Better	___ Worse	While at work	___ Better	___ Worse
After work or intense activity	___ Better	___ Worse	While performing acts of daily living	___ Better	___ Worse
There is no timing	___ Better	___ Worse	Nothing makes the pain better or worse	___ Better	___ Worse

Please check box that corresponds to any health problems in your family:

Respiratory	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
Hypertension	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
GI/GU Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
Skin Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
Neurological	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
Arthritis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children
Hypertension	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Self	☐ Children

If any of your family members are deceased, please list their age at death and the cause:

Doctor's Notes: