

Patient name: _____

Date: _____

Injury history. General: (cont'd)

Was the seat broken? Yes No
Lap belt: Wearing Not wearing Don't know
Shoulder belt: None Wearing Not wearing
 Don't know

Did air bag deploy? Yes No (No air bag in car)
If yes, were you struck? Yes No
How was your body positioned? Good Forward lean

Other _____

Head Position: Forward Left ___° Right ___°
 Up ___° Down ___°

Hands: One on wheel Two on wheel N/A

Brakes applied? Yes No
Aware of impending crash? Yes No

During the crash?

Did you strike any parts of the vehicle? Yes No

If yes, describe _____

Did your vehicle strike any objects after the crash? Yes No

If yes, describe _____

Wearing hat or glasses? Yes No
If yes, still on after crash? Yes No
Did you lose consciousness? Yes No

If yes, for how long? _____

Estimated property damage to your vehicle? \$ _____

Estimated damage to other vehicle(s): None Minimal
 Moderate Major

Were the police on-scene? Yes No

If yes, was a report made? Yes No

After the crash:

Did you experience any symptoms: Headache Dizziness
 Nausea Confusion/disorientation Neck Pain
 Paresthesia(s) (tingling)

If yes, where? _____

Extremity pain. If yes, where? _____

When did the above symptoms first appear? Immediately

_____ hours afterward _____ days afterward

Where did you go after the accident? Home Work

Hospital (name): _____

Mode of transportation: _____

Emergency department: Yes No

Were radiographs (x-rays) taken? Yes No

Body parts imaged _____

Findings _____

Lab work? Yes No

If yes, which test? _____

Cervical collar? Yes No Ice? Yes No

Heat? Yes No

Medications prescribed? _____

Are you taking above medications? Yes No

Follow-up instructions: Yes No If yes, _____

Other: _____

Treatment history:

Since your accident who have you seen for your symptoms?
 No one

Other chiropractor: Medical Doctor: Other:

1. Facility/Doctor: _____

Speciality: _____ Date first seen: _____

What treatment did you receive and when? _____

What test have you had and when? MRI _____

X-rays _____ CT Scan _____ Other _____

Did the treatment help? Yes: No: Describe: _____

Are you still being treated? Yes No

Any other Facility/Doctor? Yes: No

2. Facility/Doctor: _____

Speciality: _____ Date first seen: _____

What treatment did you receive and when? _____

What test have you had and when? MRI _____

X-rays _____ CT Scan _____ Other _____

Did the treatment help? Yes: No: Describe: _____

Are you still being treated? Yes No

Any other Facility/Doctor? Yes: No

3. Facility/Doctor: _____

Speciality: _____ Date first seen: _____

What treatment did you receive and when? _____

What test have you had and when? MRI _____

X-rays _____ CT Scan _____ Other _____

Did the treatment help? Yes: No: Describe: _____

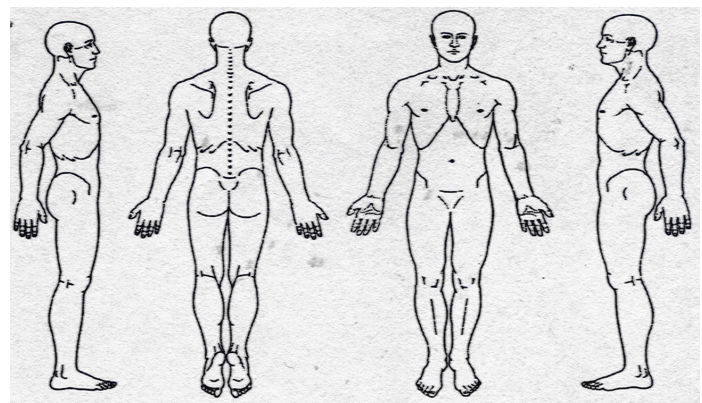
Are you still being treated? Yes No

Any other Facility/Doctor? Yes: No

Current chief complaints: Describe one symptom at a time:
List your worst symptom from the accident in severity:

Describe your symptom: _____

Where is it located? (Mark on diagram below/write type of pain)



When did it start? _____

What makes it feel worse? _____

What makes it feel better? _____

What describes the nature of your symptom?
 Sharp Dull ache Numb Shooting Burning
 Tingling Stiffness Other _____

Does it radiate? Yes No (show on picture above)

Describe the intensity of your pain (circle):
None 1 2 3 4 5 6 7 8 9 10 Unbearable

How much has your symptom interfered with your normal work (including both work outside the home and housework)?
 Not at all A little bit Moderately
 Quite a bit Extremely Can not do at all

How much time has this symptom interfered with your social activities (like visiting with friends, relatives)?
 All of the time Most of the time Some of the time
 A little of the time None of the time

How often do you experience your symptoms?
 Constantly (76-100% of the day)
 Frequently (51-75% of the day)
 Occasionally (26-50% of the day)
 Intermittently (0-25% of the day)

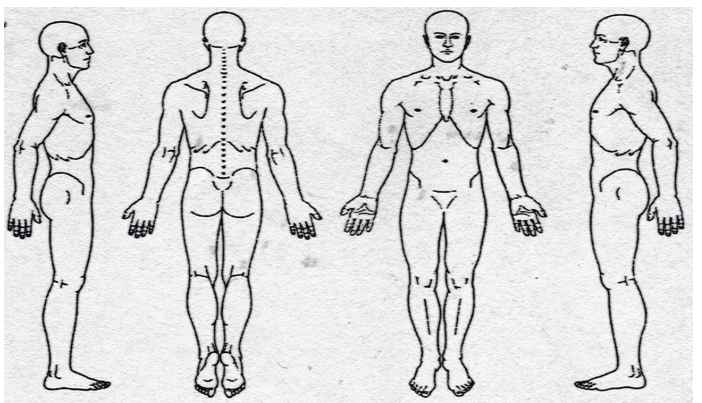
How are your symptoms changing?
 Getting Better
 Not Changing
 Getting Worse

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Doctor's Notes:

Current chief complaints: Describe one symptom at a time:
List your second symptom from the accident in severity:

Describe your symptom: _____

Where is it located? (Mark on diagram below/write type of pain)



When did it start? _____

What makes it feel worse? _____

What makes it feel better? _____

What describes the nature of your symptom (write in diagram above)?
 Sharp Dull ache Numb Shooting Burning
 Tingling Stiffness Other _____

Does it radiate? Yes No (show on picture above)

Describe the intensity of your pain (circle):
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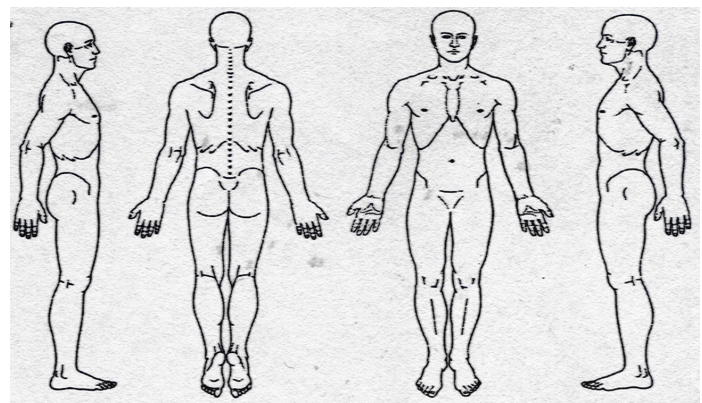
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Current chief complaints: Describe one symptom at a time:
List your next symptom from the accident in severity:

Describe your symptom: _____

Where is it located? (Mark on diagram below/write type of pain)



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What makes it feel worse? _____

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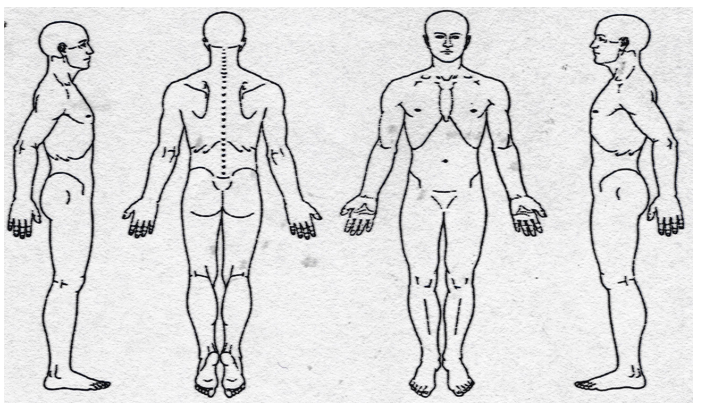
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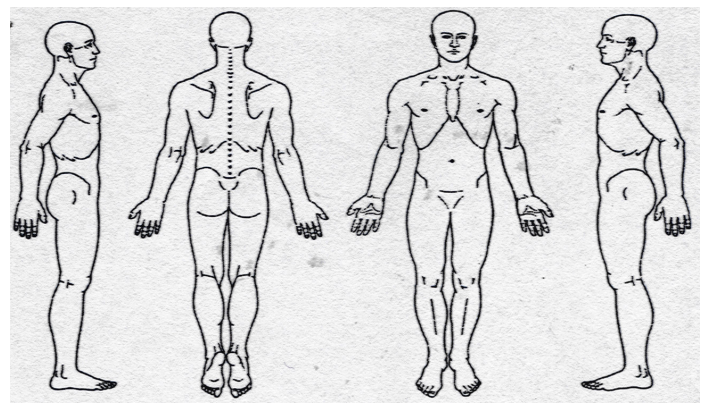
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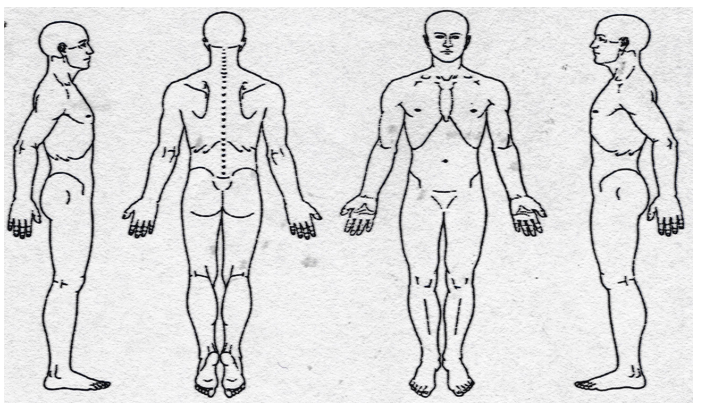
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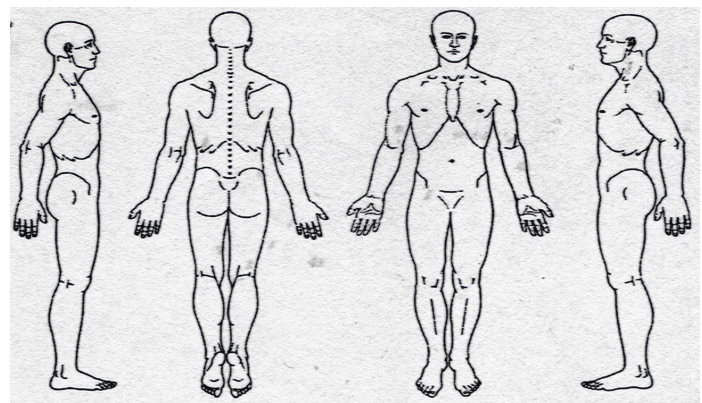
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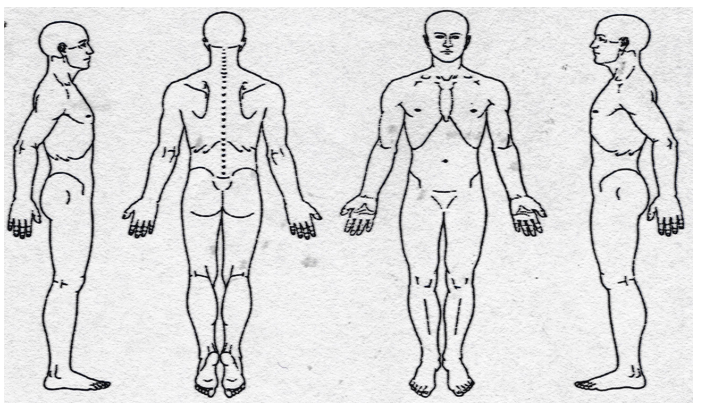
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