MOTOR VEHICLE ACCIDENT HISTORY

(please print)

Patient Information

Dr./Mr./Mrs./Ms./Miss(circle one) Marital Status(circle one) M S W D

Last Name First Name Middle Name

Address City Province Postal Code

Home Phone #_____Cell Phone #_____

Email Address_____

Date of Birth_____ Sex [ ]M [ ]F

Occupation_____Employer_____

Work Address_____Work Phone #_____

Person to Contact in an emergency_____Phone #_____

Responsible Party:

Name of Person responsible for payment of this account_____

Relationship to patient _____ Phone # _____

Address City Province Postal Code

I understand that if I am not approved for insurance coverage that I am responsible to pay for all fees that have been charged.

Signature Date

Insurance Information:

Insurance Company Name_____ Policy #_____

City/Town of Branch Office_____ Claim #_____

Adjuster First and Last Name_____

Adjuster Telephone # and Extension_____ Adjuster Fax #_____

Name of Policy Holder_____

Accident History:

1. Date of Accident: _____Time of Day: _____Road Condition: ☐ Dry ☐ Wet

2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐Back Seat

3. Number of People in your vehicle? _____

4. Were you wearing a seat belt? ☐Yes ☐No If no, go to question #6

5. If yes, were you wearing a lap belt? ☐Yes ☐No Lap belt and shoulder harness ☐Yes ☐No

6. What direction were you headed? ☐North ☐South ☐East ☐West
   On (name of street and city)_____

7. What direction was the other vehicle headed? ☐North ☐South ☐East ☐West
   On (name of street and city)_____

8. Were you struck from: ☐Behind ☐Front ☐Left Side ☐Right Side
   Other combination, please describe:_____

9. What was the position of your head during the accident?

   ☐Straight Ahead ☐Turned Right ☐Turned Left ☐Other_____

10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc)? ☐Yes ☐No
    If yes, please explain_____

11. Did any items become displaced in the vehicle (review mirror, ashtray, packages, etc)?

    ☐Yes ☐No
    If yes, please describe_____

12. Approximate speed of your car_____kph Estimated speed of the other car_____kph

13. Make/model of your car_____Make/model of other car_____

14. Were the police notified? ☐Yes ☐No **Please provide this office with a copy of the police report**

15. In your own words, please describe the accident: _____

    _____

    _____

    _____

16. Did you have any physical complaints BEFORE the accident? ☐Yes ☐No

    If yes, please describe in detail:

    _____

    _____

17. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident:_____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____

18. Were you knocked unconscious? ☐Yes ☐No If yes, for how long?_____

19. Where were you taken after the accident?_____

20. Have you been treated by another doctor since this accident? ☐Yes ☐No

    If yes, please list the doctor's name and address: _____

    _____

    What type of treatment did you receive? _____

    _____

21. Did this accident occur while you were performing tour regular job duties? ☐Yes ☐No

22. How do you feel now, what is your **number one** problem or the **one area** of greatest pain? _____

    _____

23. Please rate the level of this pain on the following scale: **0 is no pain**, **10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**

24. Since this injury occurred, is your pain: ☐Improving ☐Getting worse ☐Staying the Same

25. How often do you experience the pain?

    ☐1-2 hours/day ☐About half of the day

    ☐Most of the day ☐The pain never goes away

26. How does the pain affected your daily activities?

☐It does not affect my daily activities ☐I have had to change how I do things

☐I have had to stop doing some of my daily activities ☐I am unable to perform daily activities

27. What **increases** your pain?_____

28. What **decreases** your pain?_____

29. Have you every experienced this problem before? ☐Yes ☐No When?_____

30. Do you have a previous illness/disease which affects your present condition? ☐Yes ☐No

31. List any other complaints currently bothering you and rate your pain level for each.

a._____	0	1	2	3	4	5	6	7	8	9	10
b._____	0	1	2	3	4	5	6	7	8	9	10
c._____	0	1	2	3	4	5	6	7	8	9	10
d._____	0	1	2	3	4	5	6	7	8	9	10

32. Have you lost time from work as a result of this accident? ☐Yes ☐No

a. Type of employment_____

b. Last day worked_____

33. Have you ever been involved in an accident before? ☐Yes ☐No

a. If yes, when?_____

b. Describe the accident(s): _____

_____

c. Were you injured? ☐Yes ☐No Explain: _____

_____

34. List all the medication you are currently taking (prescription and over the counter)

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35. List all surgeries you have had (with date)

_____

_____

36. If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided (check all that apply)

____heart attack	____stroke	____arthritis	____gall bladder trouble
____diabetes	____glaucoma	____fainting spells	____kidney stones
____difficulty w/ urination	____bloody stools	____difficulty with bowel movements	
____prostrate trouble	____anemia	____cancer	____asthma
____AIDS	____ulcers	____diverticulosis	____menstrual cramping
____dizziness	____loss of memory	____chest pain	____shortness of breath
____constipation	____diarrhea	____general fatigue	____sudden weight loss

____nausea	____muscle cramping	____soreness of joints	____loss of hearing
____ears ringing	____headaches	____migraine	____epilepsy
____gout	____tuberculosis	____syphilis	____sprained ankle
____knee/hip replacement	____broken bones		

General Activities (check all that apply)

___Sleep on waterbed	___read in bed	___fall asleep in recliner chair/on couch
___sleep on stomach	___needlepoint/knitting	___use two or more pillows to sleep with
___sewing	___lift weights/wt. mach.	___play video games (_____hrs/day)
___exercise_____x/wk	___jog_____x/wk	___computer use (_____hrs/day)
___swim	___watch television (_____hrs/day)	

Please add anything else you would like the doctor to know: _____

_____

_____

_____

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosed and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered o my behalf or my dependents.

Patients signature_____ Date _____