Motor Vehicle Collision History

Name: Date: Age: Gender:

Date of Accident: Claim Number:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Your Vehicle | | | | | |
| Make: | | Model: | | Year: | |
| **Type of Vehicle:** | **Size:** | | **Speed of vehicle:** | | **Physical orientation** |
| * Car | * Subcompact | | * Stopped | | * Traffic Signal |
| * Van | * Compact | | * Decelerating | | * Traffic |
| * Sport Utility | * Mid-size | | * Accelerating | | * Stop sign |
| * Pickup Truck | * Full-size | | * Moving approximately \_\_\_\_\_\_ mph | | * Pedestrian |
| * Semi-Truck |  | | * Parking |
| * Motorcycle |  | | * Busy intersection |

|  |  |
| --- | --- |
| Accident Information | |
| **Your position in the vehicle:** | **Collison Type:** |
| * Driver | * Rear impact |
| * Front passenger | * Front impact |
| * Rear passenger: driver’s side | * Diver’s side impact |
| * Rear passenger: passenger side | * Passenger’s side impact |
| * Rear messenger: middle | * Pedestrian incident |
| * Third Row Seat |  |
| If rear impact occurred, did your vehicle hit the car in front of you? Yes No  If yes, what was the make and model of that car? | |
| If rear impact occurred, was your vehicle pushed forward from the impact? Yes No  If yes, about how far was your vehicle moved? ½ car length 1 car length 1+ car length | |
| If you were the driver, was your foot on the brake pedal? Yes No Removed by impact | |

|  |  |  |
| --- | --- | --- |
| The Other vehicle | | |
| Make: | Model: | Year: |
| **Type of vehicle:** | **Size:** | **Was the other vehicle…** |
| * Car | * Subcompact | * Larger than yours? |
| * Van | * Compact | * Smaller than yours? |
| * Sport Utility | * Mid-size | * Same size as yours? |
| * Pickup Truck | * Full-size |  |
| * Semi-Truck |  |  |

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| --- | --- | --- | --- | --- |
| Conditions at the Time of the Accident | | | | |
| **Time of Day:** | **Road Condition:** | **Visibility:** | **Visibility compromised by:** | |
| * Daylight | * Dry | * Excellent | * Setting sun | * Snow |
| * Dawn | * Wet | * Good | * Rising sun | * Traffic |
| * Dusk | * Ice | * Fair | * Fog | * Glare |
| * Night | * Snow | * Poor | * Rain | * N/A |

*The following questions concern the accidents’ moment of impact:*

|  |  |  |  |
| --- | --- | --- | --- |
| Were you… | | Restraints: | |
| * Totally unaware the accident was impending | | * Lap belt and shoulder harness * Shoulder harness only | |
| * Aware the accident was impending and did not brace for impact | | * Lap belt only | |
| * Aware the accident was impending and braced for impact | | * No restraint | |
| If you braced, how did you know the collision was about to happen? | | | |
| Did the airbag deploy? | | What position was your headrest in? | |
| * No air bag equipped | | * Top of headrest even with the top of my head | |
| * Air bag did not deploy | | * Top of headrest even with middle of my neck | |
| * Airbag deployed | | * Top of headrest even with my shoulders | |
| What position was your head in? | | Position of your body at the time of impact? | |
| * Facing straight ahead | | * Facing straight ahead | |
| * Tilted forward | | * Tilted forward | |
| * Rotated to your right | | * Rotated to your right | |
| * Rotated to your left | | * Rotated to your left | |
|  | | * Hands on the steering wheel * Reclined | |
| Were you wearing a hat or glasses? | | Was the seat back adjustment altered by the collision? | |
| * No | | * No | |
| * Yes | | * Yes | |
| Was/Were it/they still on after the collision? | | Was the seat broken? | |
| * No | | * No | |
| * Yes | | * Yes | |
| Did any parts of your body strike any part of the vehicle? | | | |
| * Head hit headrest | * Leg hit dashboard | | * Airbag hit head |
| * Head hit wind shield | * Leg hit steering wheel | | * Airbag hit torso |
| * Head hit ceiling | * Arm hit dashboard | | * Airbag hit leg |
|  | * Torso hit door | | * Airbag hit arm |
| * Head hit steering wheel | * Torso hit steering wheel | | * Arm hit steering wheel |
|  |  | |  |

Describe the movements of your head and/or body that you were aware of at the time of impact.

*The following questions concern the time period immediate following the accident:*

|  |  |
| --- | --- |
| Did you lose consciousness? | Were you able to walk unaided? |
| * No | * No |
| * Yes * How long? | * Yes |
| Immediately following the accident, were you: | Where did you go immediately following the collision? |
| * Dizzy | * Drove home |
| * Dazed | * Driven home by another |
| * Disoriented | * Drove to work |
| * Nauseated | * Drove to hospital |
| * Nervous | * Driven to hospital by another |
| * Weak | * Taken to hospital via ambulance |
| * Other: |  |

In what areas did you **immediately** feel pain?

The following day, did your discomfort: Increase Decrease No change

In the days following the accident, did pain in any new locations arise? If so, where?

Did you experience cuts and/or bruises? No Yes

If yes, where?

Since the accident, have x-rays been taken? No Yes

If yes, where?

|  |  |  |
| --- | --- | --- |
| Damage to vehicle you were in: | Police report filed? | Citations issued? |
| * Incurred damage   $ | * Yes | * Driver of the vehicle you were a passenger in |
| * Totaled: $ | * No | * Driver of other vehicle |
| * Not sure |  | * Yourself |
|  |  | * None |

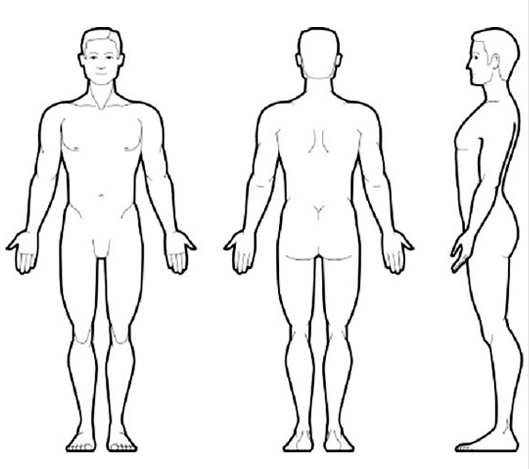
Did your major complaints exist before the accident? No Yes

If yes, please explain.

1.) Describe your main complaint:

2.) Mark the areas of complaint on your body:

R L L R



|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 3.) Please circle the rate of your pain: 0 = no pain, 10 = extreme pain | | | | | | | |
| Neck or headache | | | | Mid-back pain | | | |
| What is your neck or headache pain level at its best?  0 1 2 3 4 5 6 7 8 9 10 | | | | What is your mid-back pain level at its best?  0 1 2 3 4 5 6 7 8 9 10 | | | |
| What is your neck or headache pain level at its worst?  0 1 2 3 4 5 6 7 8 9 10 | | | | What is your mid-back pain level at its worst?  0 1 2 3 4 5 6 7 8 9 10 | | | |
| Low Back | | | | Other: | | | |
| What is your low back pain at its best?  0 1 2 3 4 5 6 7 8 9 10 | | | | Pain at its best?  0 1 2 3 4 5 6 7 8 9 10 | | | |
| What is your low back pain at its worst?  0 1 2 3 4 5 6 7 8 9 10 | | | | Pain at its worst?  0 1 2 3 4 5 6 7 8 9 10 | | | |
| 4.) The complaints began: | | | | | | | |
| * Immediately after accident | | | * Within days of the accident | | * Other: | | |
| 5.) The pain is: | | | | | | | |
| * Constant | | * Nearly constant | | | | * Comes and goes | |
| 6.) What does your main complaint feel like? | | | |  | | | |
| * Sharp | | * Dull | | | | * Achy | |
| * Throbbing | | * Shooting | | | | * Burning | |
| * Pins/needles | | * Stiff | | | | * Tight | |
| * Other: | | | |  | | | |
| 7.) How are your symptoms changing? | | | | | | | |
| * Improving | | * Worsening | | | | * No change | |
| 8.) What makes the pain worse? | | | |  | | | |
| * Bending forward | | * Lifting | | | | * Walking | |
| * Sitting | | * Getting up and down | | | | * Cold/damp weather | |
| * Driving | | * Activities in general | | | | * Looking down | |
| * Coughing | | * Bending backwards | | | | * Looking up | |
| * Sneezing | | * Lying down | | | | * Turning head | |
| * Straining to pass stool | | * Standing | | | | * reaching | |
| 9.) Symptoms are worse in | | | |  | | | |
| * Morning | * Afternoon | | | * Evening | | | * No change |
| 10.) What home care makes the pain better? | | | |  | | | |
| * Ice | | * Lying down | | | | * Stretching | |
| * Heat | | * Sitting | | | | * Medication | |
| * Rest | | * Standing | | | | * other: | |
|  | | | |  | | | |

11.) What activities are you having difficulty performing? (ex: mowing lawn, doing dishes, etc.)

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| 12.) Does the pain radiate?   * No | | 13.) Is there numbness and/or tingling?   * No | | 14.) Is there weakness?   * No | |
| Right | Left | Right | Left | Right | Left |
| * Upper arm | * Upper arm | * Upper arm | * Upper arm | * Upper arm | * Upper arm |
| * Forearm | * Forearm | * Forearm | * Forearm | * Forearm | * Forearm |
| * Hand | * Hand | * Hand | * Hand | * Hand | * Hand |
| * Buttock | * Buttock | * Buttock | * Buttock | * Buttock | * Buttock |
| * Thigh | * Thigh | * Thigh | * Thigh | * Thigh | * Thigh |
| * Calf | * Calf | * Calf | * Calf | * Calf | * Calf |
| * Foot | * Foot | * Foot | * Foot | * Foot | * Foot |

|  |  |  |
| --- | --- | --- |
| 15.) Since the accident, have you experienced… | | |
| No | Yes |  |
|  |  | Chest pain? |
|  |  | Shortness of breath? |
|  |  | Changes in bowel or bladder function? |
|  |  | Loss of bowel or bladder function? |
|  |  | Sudden, severe headaches? |
|  |  | Nausea and/or vomiting? |
|  |  | Dizziness/vertigo? |
|  |  | Poor balance? |
|  |  | Vision changes? |
|  |  | Ringing/buzzing in ears? |
|  |  | Sensitivity to noise? |
|  |  | Eyes sensitive to light? |
|  |  | Memory loss / forgetful / poor concentration? |
|  |  | Jaw pain or clicking? |
|  |  | Anxiety? |
|  |  | Problems with taste or smell? |

16.) Have you seen any other doctor for **this** complaint? None other chiropractor

medical doctor physical therapist other:

17.) Have you been treated by another doctor for ANY condition in the last twelve months?

No Yes Drs. Name:

What condition?

18.) When was your last physical exam?

Were there any concerns?

|  |  |  |
| --- | --- | --- |
| No | Yes | Inquiry |
|  |  | 19.) Do you have any spinal x-rays? (Location acquired: ) |
|  |  | 20a.) Please list your occupation: |
|  |  | 20b.) Are you a shift worker? |
|  |  | 21.) Have you missed work due to the accident?  Dates off work: |
|  |  | 22.) Can you meet all physical demands for your occupation? |

*23.) Health and Family History*

|  |  |  |  |
| --- | --- | --- | --- |
| Mom | Dad | Self | Inquiry: |
|  |  |  | Allergies |
|  |  |  | Anemia |
|  |  |  | Arthritis ( Osteo Rheumatoid Lupus Other ) |
|  |  |  | Asthma |
|  |  |  | Back problems |
|  |  |  | Bone fracture (Which bone? When? ) |
|  |  |  | Cancer (What type? ) |
|  |  |  | Constipation |
|  |  |  | Diabetes ( Type I Type II ) |
|  |  |  | Digestive Disorders ( Hiatal hernia acid reflux ulcers ) |
|  |  |  | Diarrhea |
|  |  |  | Fibromyalgia |
|  |  |  | Headaches |
|  |  |  | Heart disease |
|  |  |  | High blood pressure |
|  |  |  | High cholesterol |
|  |  |  | Kidney problems |
|  |  |  | Multiple Sclerosis |
|  |  |  | Osteoporosis/Osteopenia |
|  |  |  | Peripheral neuropathy |
|  |  |  | Poor circulation |
|  |  |  | Scoliosis |
|  |  |  | Sinus problems |
|  |  |  | Sleep apnea (Do you use a CPAP machine? No yes ) |
|  |  |  | Stroke |
|  |  |  | Thyroid problems |

24.) Please list any other conditions:

25.) Are you taking any prescription medications? No Yes

If yes, please fill out a prescription medication list at the end of this questionnaire.

26.) Do you have any known allergies to drugs? No Yes

If yes, please include that information on the prescription medication list.

27.) Please list any surgical procedures and known dates:

28.) Please describe any past injuries or falls you’ve had:

29.) Have you been in any other auto accidents? No Yes

If yes, when?

Were you treated? No Yes

If yes, by whom?

Did you completely recover? No Yes

30.) Have you had similar prior complaints? No Yes

If yes, please describe:

*Health habits*

31.) Do you have a good, supportive mattress? No Yes

What is your favorite sleeping position? Side Back Stomach

32.) Have you ever been treated by a chiropractor? No Yes

If yes, what area was treated? Low back Mid-back Neck

Did the adjustments relieve your symptoms? No Yes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 33.) How would you qualify your overall health right now? | | | | |
| * Excellent | * Very good | * Good | * Fair | * Poor |

|  |  |  |  |
| --- | --- | --- | --- |
| Inquiry: | Yes | No | Unsure |
| Do you eat mostly healthy, nutritious foods? |  |  |  |
| Do you eat breakfast? |  |  |  |
| Do you want to discuss healthy eating/weight loss coaching? |  |  |  |
| Do you take vitamins?  If yes, please include them on your prescription medication list. |  |  |  |
| Has your medical doctor advised you not to take certain vitamins? |  |  |  |
| Do you have a sensitivity to shellfish? |  |  |  |
| Do you exercise?  If yes, please list: |  |  |  |
| Do you drink alcohol?  If yes, how many drinks per week on average?  Do you have, or have you ever, had a dependence on alcohol?  If yes, are you now in recovery? |  |  |  |
| Do you take illegal drugs?  Do you have, or have you ever, had a dependence on illegal  drugs?  If yes, are you in recovery? |  |  |  |
| Do you have, or have you ever had a dependence on prescription drugs?  If yes, are you in recovery? |  |  |  |
| Do you have AIDS or HIV? |  |  |  |
| Do you have a communicable disease such as hepatitis or tuberculosis?  If yes, please list: |  |  |  |

34.) **(Women Only)** Are you pregnant? No Yes

If yes, how far along are you?

How many pregnancies have you had?

When was your last pap smear? Were findings normal?

When was your last mammogram? Were findings normal?

35.) **(Men only)** Have you had your prostate examined? No Yes

If yes, when? Were findings normal?

*Demographic Information (Optional)*

|  |  |  |
| --- | --- | --- |
| Preferred Language: | Marital Status: | Smoker Status: |
| * English | * Single | * Current, daily |
| * Spanish | * Married | * Current, occasional |
| * French | * Separated | * Former smoker |
| * German | * Divorced | * Never smoked |
| * Italian | * Widowed |  |
| * Russian |  |  |
| * Portuguese | Dependent Children? | Education level: |
| * Chinese | * No | * High school graduate |
| * Japanese | * Yes | * Vocational school |
| * Korean | If yes, how many? | * 1-4 years of college |
| * Vietnamese |  | * Graduate or more |