SUPPLEMENTAL HISTORY ACCIDENT

Lock Center Chiropractic

Name: _____ Acct#. : _____
Today's Date: _____ Date of Injury: _____Time of Injury: ___am/pm

1) Type of accident: ____ auto vs. auto ____auto vs. motorcycle
____ auto vs. truck ____auto vs. bus
____ auto vs. pedestrian ____slip and fall ___other
2) Were you the ___driver ___passenger in the front seat ___passenger in the back seat
3) Your vehicle: year _____ make _____ model _____
4) Other vehicle: year _____ make _____ model _____
5) Hands: _____one on wheel _____two on wheel _____N/A
6) How many people were in your vehicle? _____
7) What direction were you headed? _____
8) On what street? _____
9) Type of accident: I was hit / hit ___head-on ___broad side ___rear-ended ___other
10) Describe the accident in your own words:

_____

_____

11) Was the accident on-the-job? ___ yes ___no
12) Your estimated speed at moment of accident? _____ were you: __stopped
___slowing ___accelerating
13) Time of day: ___daylight ___dawn ___dusk ___dark
14) Road conditions: ___dry ___damp ___wet ___snow ___ice
15) Head restraints: ___none ___integral type ___adjustable type: ___up ___down
___don't know
16) If adjustable, was the position altered by the accident? ___ yes ___no
17) Was the seat back adjustment altered by the accident? ___ yes ___no
18) Was the seat broken? ___yes ___no Lap Belt: ____wearing ____not wearing
___don't know
Shoulder Belt: ___none ___wearing ___not wearing ___don't know
19) Did air bag deploy? ___yes ___no If yes, were you struck? ___ yes ___no
20) Body position: ___straight ____turned to the right ___turned to the left ___other
21) Head position: ___forward ___left ___right ___up ___down

DURING THE CRASH:

1) Were you aware the crash was going to happen? ___yes ___no
2) Did you brace yourself for impact? ___yes ___no
3) Did you strike any parts of the vehicle? ___yes ___no
If yes describe:_____
4) Did vehicle strike any objects after the crash? ___yes ___no
If yes describe:_____
5) Could you move all your body parts after the accident? ___yes ___no
If no describe:_____

6) Did you lose consciousness after the crash? _____yes _____no
7) Have you suffered from memory loss since the accident? ___yes ___no
If yes describe:_____
8) Wearing hat or glasses? ___yes ___no If yes, still on after crash? ___yes ___no
9) Estimated property damage to your vehicle?_____
10) Estimated property damage to other vehicle(s) ___none ___minimal ___moderate ___major
11) Were the police on-scene? ___yes ___no If yes, was a report made? ___yes ___no

EMERGENCY DEPARTMENT:

1) Has a physician treated you? ___yes ___no
If yes by whom?_____
2) Were x-rays taken? ___yes ___no Body parts x-rayed:_____
Results:_____
3)Was lab work done (blood taken)? ___yes ___no
4)Was a cervical collar prescribed? ___yes ___no Was ice prescribed? ___yes___no
5)Was medication prescribed? ___yes ___no
If yes, what?_____

DAILY LIFE:

1) Have you lost time from work as a result of this accident? ___yes ___no
2) Did this accident occur during work hours? ___yes ___no
3) Type of work at time of accident: ___office/clerical ___light labor
___moderate labor ___heavy labor
4) Before the accident did you have any of your present complaints? ___yes ___no

ORIGINAL SYMPTOMS:

PRESENT COMPLAINT(S) (please check appropriately)

___Headache
___Head seems too heavy
___Head and Shoulders tired/heavy
___Mental dullness
___Equilibrium problems
___Neck pain/stiffness
___Neck motion restricted (rt or lt)
___Upper back pain/stiffness
___Mid back pain/stiffness
___Low back pain/stiffness
___Extreme fatigue
___Excess perspiration
___Diarrhea/constipation
___Feet/hands cold
___Pins and needles in arms/legs
___Chest pain
___Eye strain/double vision
___Pain behind eyes
___Eyes sensitive to light
___Loss of taste
___Loss of smell
___Sinus trouble
___Extreme nervousness
___Anxiety
___Face is flushed/pale
___Digestive disorders/nausea
___Swollen_____
___Difficulty in prolonged car riding
___Difficulty in excessive ___standing ___walking ___riding ___bending
___Neck, low back pain/stiffness upon rising

PRESENT COMPLAINTS (continued)

___Pain radiating into ___right arm ___right leg ___left arm ___left leg
___Difficulty in excessive lifting ___light ___moderate ___heavy ___repetitive
___Pain radiating into ___neck ___base of skull ___shoulder ___arms ___hips ___legs
___Extreme fatigue

Please list any other present complaints and symptoms: _____

_____

THANK YOU, for completing this questionnaire regarding your accident. This information is necessary for the doctor in evaluating your condition.

I authorize the release of any information required, and that my benefit payments be paid directly to this clinic. I agree that I am ultimately responsible for the fees incurred in this clinic and payment will be made to Lock Center Chiropractic first and foremost upon any settlement of this claim.

Please sign below that this information is true and correct.

_____ _____
Patient/Guardian Signature Date

_____
Witness