SOUTH TAMPA CHIROPRACTIC CLINIC
AUTOMOBILE ACCIDENT HISTORY

Patient Name: _____ Todays Date: _____ Date of Injury: _____

Was the accident on the job? ❑ Yes ❑ No

Where were you seated in the vehicle? _____

Name of person driving the vehicle: _____

Your Vehicle (year, make, model): _____

Your estimated speed at the moment of the accident: _____ ❑ Stopped ❑ Slowing ❑ Accelerating

If stopped, was your foot on the brake? ❑ Yes ❑ No

Other Vehicle (year, make, model): _____

Estimated speed of the other vehicle at moment of impact: _____ ❑ Stopped ❑ Slowing ❑ Accelerating

Road conditions at the time of the accident:

❑ Dry ❑ Damp ❑ Snow ❑ Ice

Road conditions at the time of the accident:

❑ Daylight ❑ Dawn ❑ Dusk ❑ Dark

Head restraints, Seat backs:

If adjustable, was the position of the headrest altered by the accident? ❑ Yes ❑ No

Was the seat back adjustment altered by the accident? ❑ Yes ❑ No

Was the seat broken? ❑ Yes ❑ No

Seat belts and Air bags:

Were you wearing a seatbelt? ❑ Yes ❑ No ❑ Don't know

What type? ❑ Lap seat belt ❑ Shoulder seat belt ❑ Shoulder-lap seat belt

Did your air bag deploy? ❑ Yes ❑ No

If yes, were you struck? ❑ Yes ❑ No Where _____

Head and Body position:

Which way was your body pointed at the point of impact? ❑ Straight ❑ Right ❑ Left

Which way was your head pointed at the pint of impact? ❑ Straight ❑ Right ❑ Left

Patient Signature: _____

SOUTH TAMPA CHIROPRACTIC CLINIC
AUTOMOBILE ACCIDENT HISTORY

Patient Name: _____ Date: _____

ACCIDENT DIAGRAM:

In the space below, please describe, to the best of your knowledge, what happened during this accident:

DURING THE CRASH:

Position of hands: ❑ One on wheel ❑ Two on weheel ❑ N/A

Did you strike any parts of the vehicle? ❑ Yes ❑ No

If yes, please describe: _____

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

If yes, please describe: _____

Were you aware or surprised of the approaching collision? ❑ Aware ❑ Surprised

Were you wearing a hat or glasses? ❑ Yes ❑ No

If yes, were they still on after the crash? ❑ Yes ❑ No

Did you lose consciousness (black out) upon impact? ❑ Yes How long? _____ ❑ No

Did you experience a flash of light or explosion in your head? ❑ Yes ❑ No

AFTER THE CRASH:

Did you become: ❑ Confused ❑ Disoriented ❑ Light headed ❑ Dizzy

❑ Nauseated ❑ Blurred vision ❑ Ring/Buzz in ears

If you still have any of those symptoms, which ones: _____

Are you currently suffering from any of the following:

❑ Restlessness ❑ Irritable ❑ Difficulty concentrating ❑ Difficulty with memory

❑ Sleeplessness ❑ Forgetful ❑ Reduced tolerance to heat ❑ Reduced tolerance to alcohol

Did the police come to the accident scene? ❑ Yes ❑ No Is there a report? ❑ Yes ❑ No

Patient Signature: _____

SOUTH TAMPA CHIROPRACTIC CLINIC

AUTOMOBILE ACCIDENT HISTORY

Patient Name: _____ Date: _____

HOSPITAL:

Did you go to the hospital: ❑ Yes ❑ No

How did you get to the hospital? _____

Name and city of hospital: _____

Name of emergency room doctor: _____

What parts of body were x-rayed at the hospital? _____

How long did you stay in the hospital? _____

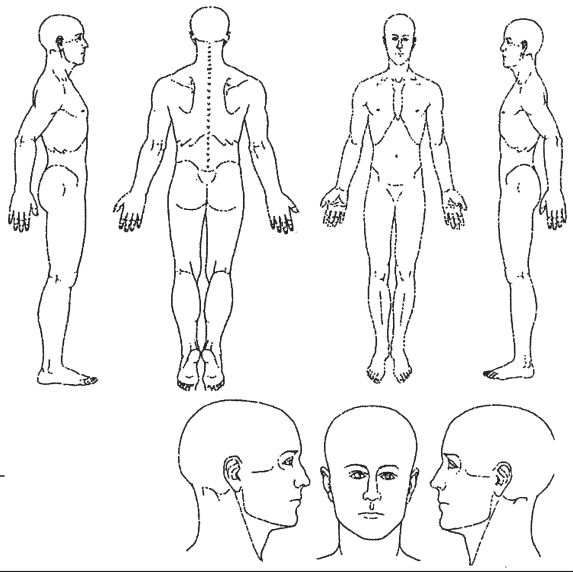
What did the hospital do for your injuries? ❑ Cervical collar ❑ Ice pack

❑ Medications_____ ❑ Follow up instructions _____

CURRENT COMPLAINTS: Please list, in detail, all current symptoms / complaints in order of severity.

1 _____

Please mark your areas of pain on the figures below



Date when symptom first appeared

How often do you experience the symptoms?

❑ Constant 100% ❑ Frequent 75%

❑ Intermittent 50% ❑ Occasional 25%

Describe any recently related accident or fall: _____

_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain: ❑ Sharp ❑ Dull ❑ Aching ❑ Burn ❑ Throb

❑ Numb ❑ Other _____

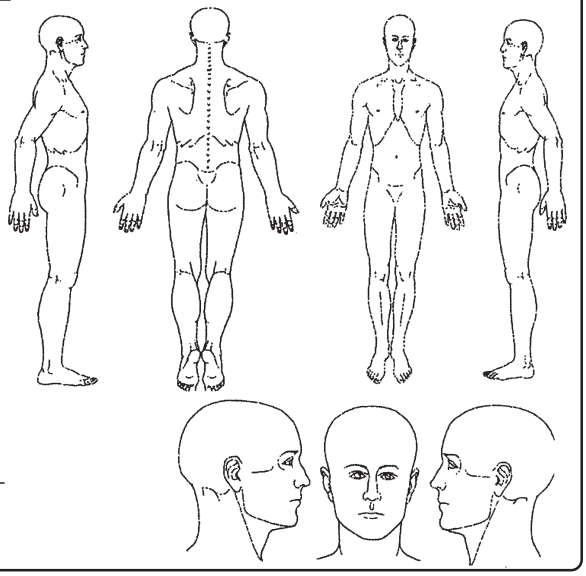
Where does the pain radiate to? _____

How bad is your pain? (indicate 0 - no pain to 10 - unbearable)

0 ---------- 5 ---------- 10

2 _____

Please mark your areas of pain on the figures below



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❑ Numb ❑ Other _____

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Patient Signature: _____

SOUTH TAMPA CHIROPRACTIC CLINIC

AUTOMOBILE ACCIDENT HISTORY

Patient Name: _____ Date: _____

3 _____

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What makes symptom increase? _____

What gives relief of symptom? _____

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❑ Numb ❑ Other _____

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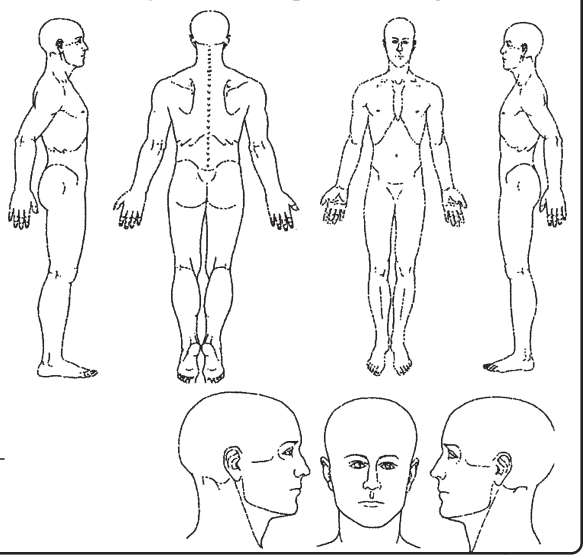

4 _____

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_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

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❑ Numb ❑ Other _____

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How bad is your pain? (indicate 0 - no pain to 10 - unbearable)

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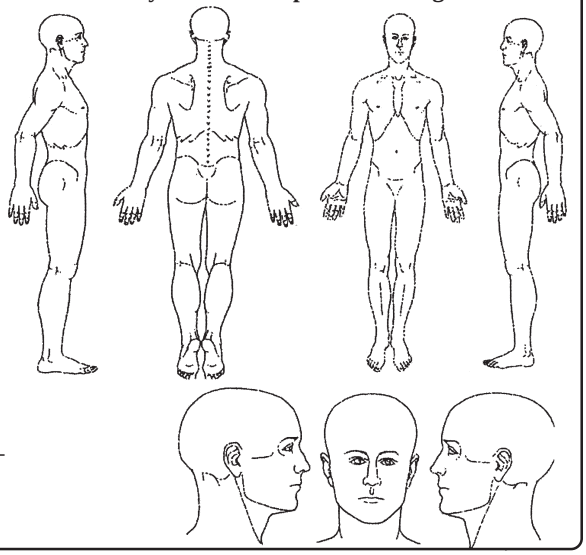

5 _____

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How often do you experience the symptoms?

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_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain: ❑ Sharp ❑ Dull ❑ Aching ❑ Burn ❑ Throb

❑ Numb ❑ Other _____

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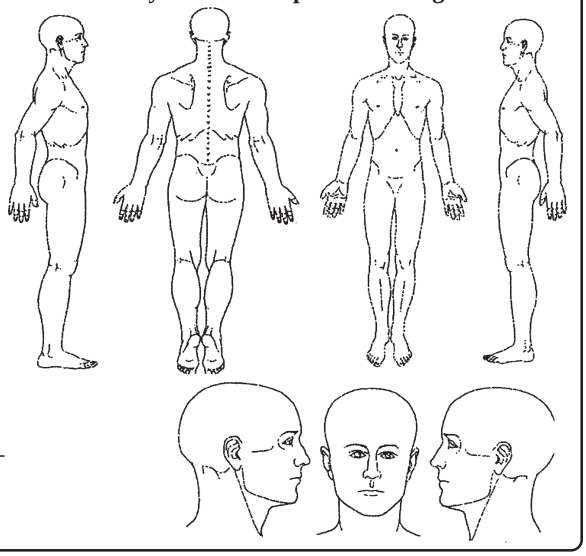

Patient Signature: _____

SOUTH TAMPA CHIROPRACTIC CLINIC
AUTOMOBILE ACCIDENT HISTORY

Patient Name: ______________________________ Date: ____________

CURRENT ACCIDENT

Please list all previous treatments for conditions related to this auto accident including all doctors visits, MRIs, X-rays, etc.

Name of Hospital: ______________________________ Phone: ____________

Date of Care: ____________________

Tests/Treatments: ____________________ Tests/Treatments: ____________________

Tests/Treatments: ____________________ Tests/Treatments: ____________________

Tests/Treatments: ____________________ Tests/Treatments: ____________________

Name of Treating Doctor: ________________ Name of Treating Doctor: ________________

Address: ____________________ Address: ____________________

Phone: ____________________ Phone: ____________________

Specialty: ____________________ Specialty: ____________________

Dates of Care: ____________________ Dates of Care: ____________________

Tests/Treatments: ____________________ Tests/Treatments: ____________________

Name of Treating Doctor: ________________ Name of Treating Doctor: ________________

Address: ____________________ Address: ____________________

Phone: ____________________ Phone: ____________________

Specialty: ____________________ Specialty: ____________________

Dates of Care: ____________________ Dates of Care: ____________________

Tests/Treatments: ____________________ Tests/Treatments: ____________________

Name of Treating Doctor: ________________ Name of Treating Doctor: ________________

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Dates of Care: ____________________ Dates of Care: ____________________

Tests/Treatments: ____________________ Tests/Treatments: ____________________

Patient Signature: ______________________________________

SOUTH TAMPA CHIROPRACTIC CLINIC

AUTOMOBILE ACCIDENT HISTORY

Patient Name: _____ Date: _____

PREVIOUS ACCIDENTS

List all treatments for conditions related to previous auto accidents including all hospital stays, doctors visits, MRIs, X-rays, etc.

Most Recent Previous Accident

Date: _____

Location: _____

Hospital: _____

Name of Treating Doctor:

_____

Address: _____

Phone #: _____

Specialty: _____

Dates of Care: _____

Tests/Treatment: _____

Name of Treating Doctor:

_____

Address: _____

Phone #: _____

Specialty: _____

Dates of Care: _____

Tests/Treatment: _____

Previous Accident

Date: _____

Location: _____

Hospital: _____

Name of Treating Doctor:

_____

Address: _____

Phone #: _____

Specialty: _____

Dates of Care: _____

Tests/Treatment: _____

Name of Treating Doctor:

_____

Address: _____

Phone #: _____

Specialty: _____

Dates of Care: _____

Tests/Treatment: _____

Name of Treating Doctor:

_____

Address: _____

Phone #: _____

Specialty: _____

Dates of Care: _____

Tests/Treatment: _____

Patient Signature: _____