Date: ______________
Patient # ______________

Automobile Accident History

Last ______________ First ______________ Middle Initial ______ Birth Date ____________ Age ______

Address ______________________ City ______________ ST________ Zip ______________

Phone (H) ______________ (W) ______________ (C) ______________

Email ______________________ May we send you our online newsletter? ☐yes ☐no

Occupation ______________________ Employer ______________________

Spouse's Name ______________ Business/Employer ______________ Spouse Phone: ______________

Who is your primary care physician? ______________________ Address: ______________

Phone: ______________ Date of last physical/exam? ______________ With Whom? ______________

Date of Accident: ______________ Time of Accident: __________ am / pm ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other ______________

Was the accident on the job? ☐Yes ☐No Where you in a company vehicle? ☐Yes ☐No

Where were you seated in the vehicle? ☐Driver ☐Passenger ☐Rear-seat ☐Other ______________

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐Yes ☐No Did you experience a flash of light or explosion in your head? ☐Yes ☐No

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

Did you go to the hospital? ☐Yes ☐No When? ☐Immediately ☐___hours later ☐___days later Which hospital? ______________

How did you get to the hospital? ______________________ How long did you stay in the hospital? ______________

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)______________________

What areas were x-rayed? ______________________What was their diagnosis? ______________

What did they recommend for follow-up care? ______________________

Was any other doctor consulted after your accident? ☐Yes ☐No If yes, please complete information below.

Dr. ______________ Specialty?______________ Date first seen:______________

Type of treatment:______________ Treatment frequency:______________ How long did you treat?________

Dr. ______________ Specialty?______________ Date first seen:______________

Type of treatment:______________ Treatment frequency:______________ How long did you treat?________

Were you wearing a seatbelt? ☐Yes ☐No If yes, did you receive any injury or bruise from the seat belt? ☐Yes ☐No

Did your head hit the head rest during the accident? ☐Yes ☐No If adjustable, was the position of the head rest altered? ☐Yes ☐No

Was the seat adjustment altered by the accident? ☐Yes ☐No Was the seat broken by the accident? ☐Yes ☐No

Did the air-bag deploy? ☐Yes ☐No If yes, did it strike you? ☐Yes ☐No If yes, where? ______________

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left Body? ☐Straight ☐Right ☐Left

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐Yes ☐No If so, were they still on after the accident? ☐Yes ☐No

YOUR CAR

List the year, make and model of the car you were in: YEAR: ___________ MAKE: ___________________ MODEL: ___________________

Was your car stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐No If no, estimate the speed of the vehicle you were in: ___________mph

If your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: ___________ MAKE: ___________________ MODEL: ___________________

Was the other car moving at the time of impact? ☐Yes ☐No If yes, what was the approximate speed of the vehicle : ___________mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

____

____

____

____

____

____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: ____________________ **Name of their auto insurance:** ____________________

Policy #: ____________________ **Claim #:** ____________________

Auto insurance phone #: ____________________ **Name of insurance adjuster:** ____________________

Driver of the other vehicle: ____________________ **Name of their auto insurance:** ____________________

Policy #: ____________________ **Claim#:** ____________________

Auto insurance phone #: ____________________ **Name of insurance adjuster:** ____________________

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: ____________________

Do you still have any of those symptoms? ☐Yes ☐No **If yes, which ones?** ____________________

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

CURRENT COMPLAINTS -List current symptoms separately in order of severity.

1* Body Part:______________________________

Date symptom first appeared: ______________

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? ______________________

What makes symptom decrease?______________________

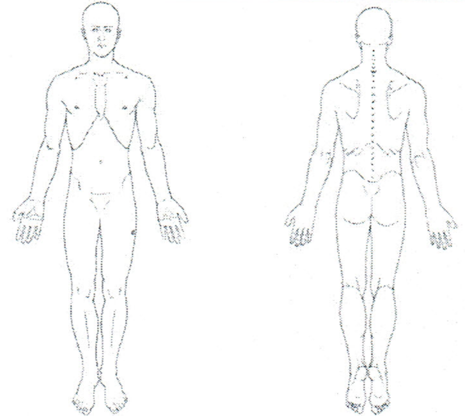
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other__________

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0◊◊◊1◊◊◊2◊◊◊3◊◊◊4◊◊◊5◊◊◊6◊◊◊7◊◊◊8◊◊◊9◊◊◊10

Where does pain radiate to? ______________________

Please mark areas of pain on the figures below



2* Body Part: ______________________________

Date symptom first appeared: ______________

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? ______________________

What makes symptom decrease?______________________

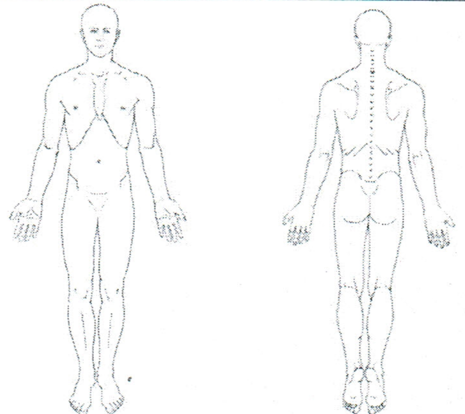
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other__________

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0◊◊◊1◊◊◊2◊◊◊3◊◊◊4◊◊◊5◊◊◊6◊◊◊7◊◊◊8◊◊◊9◊◊◊10

Where does pain radiate to? ______________________

Please mark areas of pain on the figures below



3* Body Part: ______________________________

Date symptom first appeared: ______________

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? ______________________

What makes symptom decrease?______________________

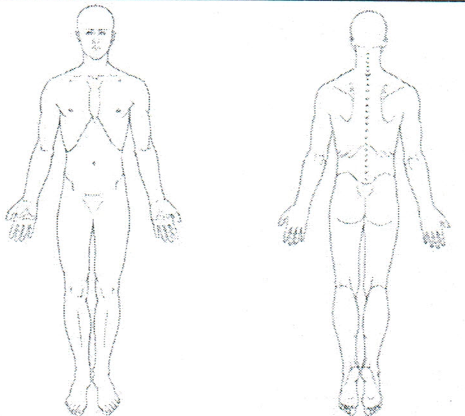
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other__________

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0◊◊◊1◊◊◊2◊◊◊3◊◊◊4◊◊◊5◊◊◊6◊◊◊7◊◊◊8◊◊◊9◊◊◊10

Where does pain radiate to? ______________________

Please mark areas of pain on the figures below



OCCUPATIONAL INFORMATION

Job involves: ☐Sitting ☐Standing How long? ______ ☐Lifting How much? ______ ☐Bending ☐Twisting ☐Turning ☐Stooping

Physical activity at work: ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

Have you missed any time from work due to the accident? ☐Yes ☐No If yes, how many days? ______ Dates: ______________

Are your work activities restricted as a result of this accident? ☐Yes ☐No If yes, please explain.______________

Do any of your work activities aggravate your present main complaints? ☐Yes ☐No If yes, please explain. ______________

____

Do you smoke? ☐yes ☐no If yes, how many packs per week?______Have you ever smoked in the past? ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? ______________

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? ______________

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? ______________

Do you have a high stress level? ☐yes ☐no If yes, list reasons:______________

Please list any medications or vitamins you are currently taking (including dosage).

______________ Frequency:__________ Dosage: __________ What is this for? __________

______________ Frequency:__________ Dosage: __________ What is this for? __________

______________ Frequency:__________ Dosage: __________ What is this for? __________

______________ Frequency:__________ Dosage: __________ What is this for? __________

X-RAY CONFIRMATION - FEMALES

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

______________________________ ______________

Patient Signature Date

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

______________________________ ______________

Patient Signature Date

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at FUNCTIONAL SPINE & WELLNESS and whom ever they designate as assistants to administer care to child.

Name of Child / Minor (please print)______________________________

Name of Parent / Guardian (please print) ______________________________

Parent / Guardian signature: ______________________________ Date: ______________