

Auto/Work Related Accident History

Patient Name _____ Pt. # _____ Date _____ Date of Accident _____

AUTO RELATED ACCIDENT

Were you the: Driver Front Passenger Rear Passenger

If a traffic violation was issued, to whom was it issued?

Number of people in accident vehicle? _____

Did the police come to the accident site? ___ Yes ___ No

Was a police report filed? ___ Yes ___ No

Were there any witnesses? ___ Yes ___ No

Were you wearing: ___ seatbelt/shoulder harness,
___ lap belt only, ___ shoulder harness only ___ none?

Was this vehicle equipped with airbags? ___ Yes ___ No

If yes, did they inflate? ___ Yes ___ No

In relation to the base of your skull, where was the headrest?

___ Above ___ Below ___ At base of skull

What did your vehicle impact? ___ Another vehicle ___ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? Yes / No

If yes, please explain: _____

Make & model of the vehicle you were occupying?

Name of the location/street on which you were traveling?

In which direction were you headed? ___ N ___ S ___ E ___ W

What was the approx. speed of your vehicle? _____ mph

Did the impact to your vehicle come from the: ___ Front ___ Rear

___ Right side ___ Left side ___ Other

During impact, were you facing ___ Right ___ Left ___ Forward

Were you ___ aware or ___ surprised by the impact?

Make and model of other vehicle involved?

Direction other vehicle was headed? ___ N ___ S ___ E ___ W

Speed of the other vehicle? _____ mph

In your words, please describe the accident: _____

WORK RELATED ACCIDENT

Was your accident directly related to your work?

___ Yes ___ No

Briefly describe the events that occurred just before
and during your accident: _____

Give the address where accident occurred:

Was anyone else present during your accident?

___ Yes ___ No

Did you report your accident to your employer?

___ Yes ___ No

What recommendations did your employer make
just after your accident? _____

Has this type of accident happened to you
before? ___ Yes ___ No

To the best of your knowledge, has this accident
occurred in your workplace before?

___ Yes ___ No

In general:

Is your job physically stressful? ___ Yes ___ No

Is your job mentally stressful? ___ Yes ___ No

Is your workplace noisy? ___ Yes ___ No

Have you changed jobs in the last year? ___ Yes ___ No

In your words, please describe the accident:

AFTER INJURY

Did the accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a Hospital or seen any other Doctor? Yes / No

When did you go? Just after the accident

The next day 2 days plus

How did you get there? Ambulance Private transportation

Name of Hospital and/or Attending doctor: _____

Was he/she a: D. C. M.D. D.O. D.D.S.

Describe any treatment you received: _____

Were X-rays taken? Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

Have your work activities been restricted as a result of this injury?

Yes No

Please check the symptoms that are a result of this accident:

<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Digestive Problem
<input type="checkbox"/> Tight sore muscles	<input type="checkbox"/> Leg and Hip Problems
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Mid-Back Pain	<input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> Lower-Back Pain	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Headaches	<input type="checkbox"/> Stiffness
<input type="checkbox"/> Sciatica	<input type="checkbox"/> TMJ Problems
<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Tingling or Numbness
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Blurred Vision

Is your condition getting worse? Yes No

Are your symptoms Constant Comes and Goes?

Indicate your degree of comfort while performing the following activities:

Lying on back:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Lying on side:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Sitting:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Standing:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Stretching:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Walking:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Running:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Sports:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Working:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Lifting:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Bending:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Kneeling:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Pulling:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful
Reaching:	<input type="checkbox"/> Comfortable	<input type="checkbox"/> Uncomfortable	<input type="checkbox"/> Painful

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities, which you are occasionally asked to perform.

<input type="checkbox"/> Standing	<input type="checkbox"/> Driving	<input type="checkbox"/> Operating equipment
<input type="checkbox"/> Sitting	<input type="checkbox"/> Twisting	<input type="checkbox"/> Work with arms above head
<input type="checkbox"/> Walking	<input type="checkbox"/> Crawling	<input type="checkbox"/> Typing
<input type="checkbox"/> Lifting	<input type="checkbox"/> Bending	<input type="checkbox"/> Stooping
<input type="checkbox"/> Other	_____	

Prior to the injury, were you capable of working on an equal basis with others your age? Yes No N/A

Do you work with others who can help you with any heavy lifting? Yes No N/A

While in recovery is there any light duty work you could request? Yes No N/A

ADDITIONAL INSURANCE

2nd Insurance (Auto or Worker's Comp)

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy # _____

Claim # _____

Insured's SS #: _____

Insured's DOB ____/____/____

Insured's Employer: _____

Agent's Name: _____

Have you retained an attorney: Yes No

If yes, whom: _____

His/Her phone #: _____

I, _____, understand that I am ultimately responsible for my account.

Signature

_____/_____/____

Date