

ADVANCED CHIROPRACTIC NUTRITION CENTER
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Personal Injury ACCIDENT REPORT

Your Social Security# _____

Today's Date _____

Patient Name: _____ Sex: M F Date of Birth: _____ Age _____

Address: _____ # _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone/Pager: _____

Employer: _____ Avg. hours worked per week: _____ Occupation: _____

Marital Status: S M D W Sep E-mail: _____

Children's Names and Ages(if applicable): _____

Emergency Contact: _____ Phone: _____

How did you here about our office? _____

Have you been treated by a Chiropractor before? No Yes Dr.'s Name: _____

THE ACCIDENT: Date of Accident _____ Time of Day _____ a.m. / p.m. (Circle)

Location of Accident: _____

Describe the accident in your own words: _____

Current Symptoms/Injuries:

Please check if you have had any of the following symptoms since your injury:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Head feels heavy |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension | <input type="checkbox"/> Light bothers eyes |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred | <input type="checkbox"/> Pins & Needles Legs |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea/Upset Stomach | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles Arms |

Since the injury occurred, are your symptoms: improving getting worse same varies w/activity

• Rate the severity of your pain – from **1** (least) to **10** (severe pain): (Circle one) 1 2 3 4 5 6 7 8 9 10

• Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

• Is it constant? No Yes Does it come and go? No Yes How often? _____

Does it interfere with your: Work Sleep Daily Routine Recreation Other: _____

Activities/movements that are painful to perform: Sitting Standing Walking Bending Lying down

Other: _____

Mark an X on the picture where you have pain.



Testing:

Have you had any specialized tests? MRI CT Scan No Yes List: _____

Do you have any herniated or bulging discs? No Yes Where?: _____

Do you have any current x-rays? (within past year) No Yes Where?: _____

Home Treatment: (Circle all that apply.)

What treatment have you tried? Ice Moist Heat Dry heat/Heating Pad Massage Bedrest Medication

List all medications and how often taken: _____

___ Ibuprofen ___ Tylenol ___ Aspirin _____

List all nutritional supplements and amounts taken: _____

Family Physician: Dr. _____ last seen when/for what? _____

Females: Any possibility of pregnancy? No Yes Date last menstrual period began: _____

Type of birth control used: Birth Control Pill Hysterectomy Tubal Ligation Husband Vasectomy
Abstinence (no sex) Other: _____

HISTORY PRIOR TO THE ACCIDENT

Have you ever had a litigated claim following an accident? No Yes When? _____

Did you receive a settlement? No Yes Have you been rated with a permanent impairment? No Yes

Prior accidents/injuries:

Auto/Cycle (type of vehicle/mph): _____

Slips/falls/lifting injuries: _____

Workers' Comp. Injuries: _____

Any loss of consciousness resulting from accident or injury? _____

List any broken bones & type of injury _____

List Sports activities (include school sports, even if no injuries) _____

Surgeries: (Indicate surgeries you have had and your approximate age)

___ Tonsillectomy ___ Eye ___ Hysterectomy ___ Vasectomy ___ Neck ___ Skin Cancer
___ Hemorrhoid ___ Heart ___ D&C ___ Hernia ___ Back ___ Other Cancer
___ Appendix ___ Stomach ___ Gall Bladder ___ Knee ___ Tubal Ligation ___ Other _____

Hospital Stays (Surgical and Otherwise): _____

Lifestyle Information: (Circle all that apply)

Smoking: Do you currently smoke? No Yes Cigarettes Cigars Smokeless Tobacco Did you smoke previously? No Yes

Packs/Day ___ # Yrs Smoking ___; # Yrs Stopped: ___; Times Quit ___

Coffee - #Cups/Day ___; Reg. Decaf. **Tea:** #Cups/Glasses/Day ___ **Soda:** #Day ___ Reg. No Caffeine Diet

Alcoholic Beverages: Current: Never Socially Weekends Daily **Type:** Beer Wine Alcohol Amt. _____

Prior: Never Socially Weekends Daily **Type:** Beer Wine Alcohol Amt. _____

Exercise: None Very Little Moderate Daily Heavy List Types: _____

Hobbies: _____ **Stresses:** _____

Has your weight changed over the past year? No Yes Up Down How much? _____ # Have you dieted? _____

ADDITIONAL ACCIDENT INFORMATION:

Accident Site: Road/Street Name: _____ City/State _____

What direction were you headed? _____ Other vehicle? _____

Driving conditions: Dry Wet Icy Other _____

What speed were you traveling? _____ MPH What speed was the other vehicle traveling? _____ MPH

Vehicle: Were you in your own vehicle? No Yes Owner of vehicle: _____

Your Car: Make: _____ Model: _____ Year _____ Amt.of Damage \$ _____

Were you wearing a seatbelt? No Yes Lap Shoulder Did it work properly? No Yes

Was the vehicle equipped with airbags? No Yes Did they inflate properly? No Yes

Did your seat have a headrest? No Yes What was position of the headrest? Low Mid High

Other vehicle(s):

Other Car: Make _____ Model _____ Year _____ Amt.of Damage \$ _____

Other Car: Make _____ Model _____ Year _____ Amt.of Damage \$ _____

Impact: Did any part of your body strike anything in the vehicle? No Yes Describe: _____

Were both of your hands on the wheel? No Yes If not, which one was on the wheel? Left Right

Was your foot on the brake? No Yes Which one was on the brake? Left Right

At the time of impact, which position was your head in? _____

Did you see the accident coming? No Yes Were you braced for impact? No Yes

When the accident occurred, were you... At a complete stop? Breaking? Accelerating? Other _____

Did your car strike another vehicle? No Yes Did the vehicle strike another vehicle? No Yes

Did your vehicle impact a structure? No Yes Explain: _____

Was there more than one impact? No Yes Describe: _____

Were you struck from: Behind Front Driver's side Passenger side Other _____

Police:

Did police come to the accident site? No Yes Was a police report filed? No Yes

Do you have a copy of the accident report? No Yes Were there any witnesses? No Yes

Was a traffic violation issued? No Yes To Whom? _____

After the Accident:

When did you first notice your injuries or symptoms? _____

Did you lose consciousness after the accident? No Yes How long? _____

Describe how you felt immediately after the accident. _____

Did you drive yourself home? No Yes How did you get home? _____

Treatment after this accident:

Did you go to the hospital? No Yes When? Immediately after Next Day Other _____

How did you get to the hospital? Rescue/Ambulance Drove Self Private Transportation Other: _____

Name of hospital: _____ Date: _____

What treatment was received? _____ Dr. _____

Any X-rays taken? No Yes What area of your body? _____

Were you hospitalized overnight? No Yes Have you seen your family physician since the accident? _____

Other:

Did you notify **YOUR** health insurance carrier? No Yes Insurance Co. _____

Claim #: _____ Adjuster: _____ Phone: _____

Do you have secondary insurance? No Yes Insurance Co. _____

Have you been able to work since this injury? No Yes How many days have you missed? _____

Prior to the injury, were you able to work on an equal basis with others your age? No Yes

Have you had previous complaints in the injured area? No Yes

If yes, describe: _____

Have you retained an attorney? No Yes

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone Number: _____

Release of Medical Information to Insurance Carrier:

I give permission to **ADVANCED CHIROPRACTIC NUTRITION CENTER** to release all medical and chiropractic information including consultation, history, reports, examination and treatment in relation to my care to my insurance carrier in order to facilitate processing of my health care claims.

I certify that the above information is correct to the best of my knowledge:

Patient Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____