APRILE CHIROPRACTIC CENTER - ACCIDENT HISTORY FORM

Full Name ____ Today's Date ________________________

Address ______________________________________ City ________________ State ____ Zip _________

Home Phone ______________ Work Phone ________________ Occupation ____________light duty____regular duty___

Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Age _____ Birthday ____/____/____

No. of children ___ Are you currently pregnant? ☐ Yes ☐No

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ______________SS# ________________

*Email ______________________

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements, appt reminders, & promotions.

HISTORY OF ACCIDENT (check all that apply)

1. **Date of Accident** ______________ Time of Accident ______________
2. Description of Accident ____

____

____

____

3. Location of Accident Street _________________________ City ______________________ State ____
4. ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other ____
5. ☐ Traveling ☐ Stopped facing ☐ N ☐ S ☐ E ☐ W ☐ Unknown Direction
6. **YOUR** Vehicle Type: ☐ Compact ☐ Midsize ☐ Truck ☐ Sport Utility ☐ Van ☐ Semi-truck
7. **OTHER** Vehicle Type(s): ☐ Compact ☐ Midsize ☐ Truck ☐ Sport Utility ☐ Van ☐ Semi-truck
8. Who was issued the citation? ☐ Nobody, we exchanged insurance info ☐ I was / My party ☐ Other party
9. ☐ Stopped and rear-ended ☐ Moving and rear-ended ☐ Slowing down to make stop / turn and rear-ended

   ☐ Head-on collision – other vehicle traveling in opposite direction ☐ Side swiped RIGHT / LEFT ☐ Rolled over

   ☐ Another vehicle ran stop sign / red light ☐ Lost control of vehicl ☐ Spun around ☐ T-boned RIGHT / LEFT
10. If rear-ended, did the force of the impact cause your vehicle to collide with another vehicle? ☐ Yes ☐ No
11. **Road conditions** at the time of the accident: ☐ Wet ☐ Dry ☐ Icy ☐ Foggy ☐ Windy ☐ Other _____________

    Visibility: Poor Fair Good
12. Approximate **speed** of **YOUR** vehicle: _______mph
13. Approximate **speed** of **OTHER** vehicle: _______mph
14. Was there damage to your vehicle? ☐ Yes ☐ no ☐ Totaled ☐ Extensive ☐ Moderate ☐ Mild
15. Did your vehicle have an air bag? ☐ Yes ☐ no If yes, did it deploy? ☐ Yes ☐ No
16. Were you wearing a **seat belt**? ☐ Yes ☐ No Were you aware of the impending collision? ☐ Yes ☐ No
17. What was the position of the **headrest**? Braced for impact? ☐ Yes ☐ No

    ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck ☐ Other _______

    Direction of head - ☐ Facing straight ☐ Turned Left ☐ Turned Right
18. Did you strike any objects in the car? ☐ Yes ☐ No
19. If yes, then what? ☐ Steering column ☐ Rearview mirror ☐ Seat broke ☐ Dashboard

    ☐ Door frame ☐ Headrest ☐ Jarred or thrown about ☐ Windshield ☐ Headrest

☐ Cannot remember details (dazed) ☐ Other ____________________

20. What portion of your body did you strike? ☐ Head ☐ Chest ☐ Face ☐ Arms ☐ Hands ☐ Legs ☐ Knees
☐ Shoulder ☐ Hip ☐ Other ____________________
21. As a result of the accident were you? ☐ not injured ☐ cut/bleeding ☐ bruised ☐ dizzy ☐ nauseas ☐ blurred vision
☐ unconscious ☐ ringing/buzz in ears ☐ partially paralyzed ☐ other __________
22. If cut, bruised, and/or partially paralyzed please explain where ____________________
23. If you experienced immediate pain, please indicate where:

☐	Headache	☐ Left	☐ Right	☐	Neck pain	☐ Left	☐ Right
☐	Upper-back pain	☐ Left	☐ Right	☐	Mid-back pain	☐ Left	☐ Right
☐	Chest pain	☐ Left	☐ Right	☐	Low-back pain	☐ Left	☐ Right
☐	Arm	☐ Left	☐ Right	☐	Elbow	☐ Left	☐ Right
☐	Knee	☐ Left	☐ Right	☐	Leg	☐ Left	☐ Right
☐	Other ____________________						

24. After the accident, did you? ☐ go home ☐ go to work ☐ go about your business ☐ go to the hospital

HOSPITALIZATION

25. If taken to the hospital, how did you get there? ☐ Ambulance ☐ Driven by friend / relative ☐ Drove yourself ☐ Went later
26. If you went later, then when? ______________ Name of hospital ____________________
27. Were you seen in the emergency room? ☐ Yes ☐ No
28. Were you admitted to the hospital? ☐ Yes ☐ No
29. If admitted, how long did you stay? ____________________
30. Name of admitting or hospital physician? ____________________
31. What was done in the emergency room or hospital? ☐ Examination ☐ Stitches ☐ X-rays ☐ Surgery
☐ Physical Therapy ☐ Casting ☐ Cervical collar ☐ Prescription(s) ____________________
☐ Other ____________________
32. After being released, what did you do? ☐ Return home to bed ☐ Return to work ☐ Return to the emergency room
☐ Other ____________________
33. When did you first consult a physician? ☐ Same day ☐ Following day ☐ Within a few days
☐ Did not consult one ☐ Other ____________________

(If patient consulted this office, skip to PAST HISTORY)

34. Who did you consult? Dr. ______________ ☐ Family Physician ☐ Chiropractor ☐ Orthopedist
☐ Osteopath ☐ Neurologist ☐ Other ____________________
35. What did the doctor do? ☐ Chiropractic manipulation ☐ Examination ☐ X-rays ☐ Injections ☐ Traction
☐ Physiotherapy ☐ Prescription(s) ______________ ☐ Other ______________
36. How long were you under this doctor's care? ____________________
37. Are you still under this doctor's care? ☐ Yes ☐ No
38. Frequency or number of visits now? ______________
39. Did the doctor refer you to or have you been to any other physician? ☐ Yes ☐ No
If yes, explain: ____________________

40. Were you sent for an independent medical examination? ☐ Yes ☐ No

If yes, to whom? ____________________

41. Other pertinent information ____________________

____

____

PAST MEDICAL HISTORY

42. Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

☐ Cancer ☐ depression ☐ heart disease ☐ hepatitis ☐ pacemaker ☐ high blood pressure ☐ stroke ☐ digestive disorder

☐ Pregnancies ☐ other ____________________

43. For patients over 13 yrs. Old. ☐ Smoking –packs per day ____ ☐ alcohol drinks/week _____

☐ coffee/caffeine drinks-cups/day____ ☐ alcohol dependence ☐ drug dependences

44. Please list all allergies including **allergies** to medications____________________

____

45. List all **medications** you are currently taking (including vitamins & supplements) ____________________

____

46. List any **surgeries, fractures, serious illnesses, or hospitalizations**.____________________

____

Family health history:

If a family member has any of the following, please mark the appropriate box:

☐ Cancer ☐ diabetes ☐ heart problems ☐ high blood pressure ☐ other ____________________

Please list the family member with the condition in the above question.____________________

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47. Have you ever been in any **previous accident** of any kind? (Including auto, work related, or slip and fall) ☐ Yes ☐ No

If yes, please give dates and details ____________________

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48. Were you rendered **permanently impaired**? ☐ Yes what % ___________ ☐ No

49. Has any other physician **prior** to this accident ever treated you for **neck or back problems**? ☐ Yes ☐ No

If yes, please explain ____________________

____

____

50. Have you had any previous **surgeries** or any conditions that I should know about? ☐ Yes ☐ No

If yes, please explain ____________________

____

51. Were you symptom free and in good health before this accident? ☐ Yes ☐ No

If no, please explain ____________________

____

PRESENT COMPLAINTS

52. Since the accident are your symptoms ☐ improving ☐ staying the same ☐ getting worse

____

53. Please list your current problem areas (prioritize with worst being #1) please use diagram attached for description as well.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

54. Have you lost any time from work since the accident? ☐ Yes ☐ No

55. If yes, how many days? ______________ Are you still off work? ☐ Yes ☐ No

56. Date returned ____________________ Job description ____

57. In what way have your injuries affected your ability to work? ____

____

58. Can you perform physical work activities? ☐ Yes ☐ No if no why____________________________________

____

59. Have your injuries created a financial burden to you and/or your family? ☐ Yes ☐ No if yes explain why________________

____

60. Please check the following you are having problems with ☐ standing ☐ sitting ☐ walking ☐ seeing ☐ hearing ☐ tasting ☐ smelling ☐ eating ☐ reading ☐ writing ☐ holding ☐ climbing ☐ bending ☐ twisting ☐ carrying ☐ lifting ☐ pulling ☐ pushing ☐exercising

☐ Loss of sexual drive ☐ restful sleeping ☐ irritability ☐ nervousness ☐ loss of concentration ☐ driving ☐ other________________

61. If you have an attorney representing you, please give name, address, and telephone number:

Name ________________________________ Firm ______________________________________

Address ____ City _____________________________

State _____ Zip _____________ Phone ______________________________

I certify that all of the above personal health information on pages one, two, three, & four are complete and accurate to the best of my knowledge.

I agree to notify the doctor immediately whenever I have changes in my health condition in the future.

Patient Signature or guardian ___________________________ Date _____________________