Seattle Chiropractic & Massage Center

AUTO ACCIDENT HISTORY

Name: _____ Todays Date(___ /___ /_____) Date of Accident(___ / ___ /_____)

INFORMATION ABOUT THE MOTOR VEHICLE ACCIDENT:

City where accident occurred_____ Were you the: ( )DRIVER ( )PASSENGER ( )PEDESTRIAN
Were you struck from: ( )FRONT ( ) REAR ( )LEFT SIDE ( )RIGHT SIDE
Were you aware of the collision prior to impact or did it catch you by surprise? ( )AWARE ( )UNAWARE
What position was your head facing during impact? ( )FORWARD ( )LEFT ( )RIGHT ( )OTHER_____
Were you wearing a seatbelt with a shoulder harness? ( )YES ( )NO ( )LAP BELT ONLY ( )UNKNOWN
Head Restraint: ( )NONE ( )ADJUSTIBLE ( )UP ( )DOWN ( )SEATBACK ONLY ( )DON'T KNOW
Did Airbags Deploy? ( )YES ( )NO If YES, were you struck by Airbags? ( )YES ( )NO
Road conditions were: ( ) DRY ( )WET ( )ICY ( )SNOW Did the police show up to the scene? ( )YES ( )NO
Who was at fault? ( )Driver of other vehicle ( )Driver of my vehicle ( )Myself ( )Don't Know
Please describe the accident (i.e., Rear-ended, Side-swiped, Head-on etc.) _____
_____
_____
Did you receive any visible cuts or bruises as a result of the accident? ( )YES ( )NO If YES, Where? _____
_____
Did you strike any parts of your body on the interior of the vehicle? ( )YES ( )NO If YES, Explain? _____
_____
Following the collision, did you experience: ( )DIZZINESS ( )NAUSEA ( )CONFUSION/DISORIENTATION ( )HEADACHES
Did your pain begin: ( )IMMEDIATELY ( )HOURS LATER ( )DAYS LATER ( )OTHER _____

INFORMATION ABOUT THE VEHICLE YOU WERE IN:

Year:_____ Make (Ex. HONDA):_____ Model (Ex. CIVIC): _____
What was the estimated speed of your vehicle during impact? _____ (MPH)
Was your vehicle: ( ) SLOWING DOWN ( ) ACCELERATING ( ) STEADY SPEED ( ) STOPPED ( ) PARKED
Was you vehicle pushed forward after impact? ( )YES ( )NO If YES, How much? _____
Did your vehicle strike any other objects after the crash? _____
Estimated amount of damage to your vehicle? $ _____
Estimated damage to other vehicle? ( )NONE ( )MINIMAL ( )MODERATE ( )MAJOR

INFORMATION ABOUT OTHER VEHICLE(S) INVOLVED IN ACCIDENT:

Year: _____ Make (Ex. HONDA): _____ Model (Ex. CIVIC): _____
What was the estimated speed of the other vehicle during impact? _____(MPH)
Was the other vehicle: ( ) SLOWING DOWN ( ) ACCELERATING ( ) STEADY SPEED ( ) STOPPED ( ) PARKED
If more than one other vehicle was involved, please explain. _____
_____

HOSPITAL EMERGENCY ROOM QUESTIONS:

Were you taken to a hospital/emergency room after the accident? ( )YES ( )NO DATE (If not same day) __ /__ /____
Name of hospital/emergency room? _____ City _____
How did you get to the hospital/emergency room? ( )AMBULANCE ( )YOURSELF ( )SOMEONE ELSE DROVE YOU
Were X-Rays Taken? ( )YES ( )NO If yes, were X-Rays taken: ( )Laying down ( )Standing ( )Seated

PLEASE COMPLETE OTHER SIDE >>>>>>>>>>>>>>>>>>>>>>>>→

Which areas of your body were X-Rayed? ( )NECK ( )MID BACK ( )LOW BACK ( )OTHER _____
Was any treatment administered at the hospital? ( )ICE ( )HEAT ( )CERVICAL COLLAR ( )MEDICATION
FOLLOW UP INSTRUCTIONS: _____

OTHER HEALTH CARE PROVIDERS SEEN AFTER THE ACCIDENT:

1)Dr. _____ Specialty: _____ Referred By: _____

Date first seen: (__ / __ / ____) Treatment type: _____
Treatment frequency/duration _____ Currently treating? ( )YES ( )NO
Any disability? ( ) YES ( ) NO If YES, please describe _____
Special tests (X-Rays, MRI, CT): _____ Did treatments help? ( )YES ( )NO

2) Dr. _____ Specialty: _____ Referred By: _____
Date first seen: (__ / __ / ____) Treatment type: _____
Treatment frequency/duration _____ Currently treating? ( )YES ( )NO
Any disability? ( ) YES ( ) NO If YES, please describe _____
Special tests (X-Rays, MRI, CT): _____ Did treatments help? ( )YES ( )NO

QUESTIONS ABOUT YOUR WORK AND SOCIAL HISTORY:

What is your occupation? _____
Employer at time of injury? _____ Employers Phone #? _____
Employers Address: _____
Is this accident an *on the job injury*? ( )YES ( )NO If YES, have you reported it to your employer? ( )YES ( )NO
Has an *on the job injury claim* been filed? ( )YES ( )NO If YES, what is the claim number? _____
Have you lost time from work as a result of this injury? ( )YES ( )NO If YES, please list dates _____
Date you returned to work or expect to return to work _____
I am currently working: ( )FULL-TIME ( )PART-TIME _____ (HRS/WEEK) ( )REGULAR DUTY ( )LIGHT-DUTY

PLEASE CHECK THOSE ACTIVITIES THAT ARE REQUIRED OF YOU AT WORK:

	LIFTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to ___ lbs
	CARRYING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to ___ lbs
	PUSHING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to ___ lbs
	PULLING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to ___ lbs
	SITTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	STANDING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	WALKING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	BENDING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	

	REACHING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	TWISTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	COMPUTER WORK		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	

PLEASE CHECK THOSE ACTIVITIES THAT CAUSE WORSENING OF YOUR ACCIDENT RELATED INJURY:

	LIFTING		SITTING		TWISTING		HOUSE WORK		
	CARRYING		STANDING		REACHING		YARD WORK		
	PUSHING		WALKING		EXERCISING		DRIVING		
	PULLING		BENDING		COMPUTER WORK		OTHER _____		

SIGNATURE: _____ **DATE: _____**