ACCIDENT HISTORY REPORT Date:_____

❑ P.I. ❑ Workers' Compensation ❑ Independent Medical Examination ❑ Other

Name: _____
Address: _____
Date of Accident: _____
Date of Examination End (eval.): _____
Employer: _____
Occupation: _____
Referred by:
Person: _____
Doctor: _____
Attorney: _____
Carrier: _____ Name of Rep:_____

HISTORY
Please describe how the accident or injury occurred:

_____
_____
_____
_____
_____
_____
_____

Were you:
❑ Driver ❑ Passenger (front; rear seat) ❑ Pedestrian ❑ Other_____
Traveling or stop- facing: ❑ North ❑ South ❑ East ❑ West
Location: Street_____ City:_____State:_____

DESCRIPTION OF ACCIDENT (Check or circle appropriate description)

❑ Stopped facing down for (traffic / red light / stop sign) and was struck in the rear by another vehicle.
❑ Was pushed into the vehicle in front of his/hers
❑ Slowing down to execute a turn and was struck in the rear by another vehicle.
❑ Was side swiped by another vehicle traveling in the same direction.
❑ Another vehicle traveling in the opposite direction collided head-on with the vehicle in which (he/she) was riding.
❑ Another vehicle traveling in the opposite direction suddenly turned in front of (his/her) vehicle causing the two vehicles to collide.
❑ Another vehicle made an improper turn and caused the two vehicles to collide.
❑ Another vehicle ran a (red light/stop sign) and struck (his/her) vehicle (broadside / in the rear / in the front end).
❑ The vehicle in which (he/she) was riding was struck by another vehicle causing it to (spin around/roll over).
❑ The patient was involved in a multi-car collision.
❑ The patient was involved in a motor vehicle collision.
❑ The driver other vehicle in which (he/she) was riding lost control and (struck another vehicle/ran off the road / struck: an object –

describe_____).

- ❑ The patient was thrown from the car to the pavement.
- ❑ The patient injured (his/her) back in a lifting accident.
- ❑ The patient was (a pedestrian/riding a bicycle/riding a motorcycle) and was struck by a motor vehicle.

Was the patient wearing a seat belt? Yes No
Did he/she strike any object inside the car? Yes No
Select the objects that were struck:

- ❑ Windshield
- ❑ Headrest
- ❑ Dashboard
- ❑ Steering wheel
- ❑ Rear view mirror
- ❑ Jarred or was thrown about
- ❑ Rear window of pick up
- ❑ Back of seat
- ❑ Seat broke
- ❑ Doorframe
- ❑ Side window
- ❑ Dazed cannot remember details

Select from the following list, the part or parts of the body that struck the object:

- ❑ Head ❑ Face ❑ Chest ❑ Neck
- ❑ Back ❑ Shoulder(s)(Rt/Lt) ❑ Arms (Rt/Lt) ❑ Elbow(s) (Rt/Lt)
- ❑ Wrist(s)(Rt/Lt) ❑ Leg(s)(Rt/Lt) ❑ Knee(s) (Rt/Lt) ❑ Ankle(s) (Rt/Lt)
- ❑ Other_____

Was the patient: ❑ Unconscious ❑ Cut or Bleeding (describe) ❑ Neither

If applicable, indicate normal or abnormal sensations experienced by the patient immediately following the accident:

- ❑ Felt no immediate pain
- ❑ Semiconscious state
- ❑ Upper extremity pain (Rt/Lt)
- ❑ Pain began shortly after the accident
- ❑ Low back pain - (Rt/Lt)
- ❑ Other _____
- ❑ Head pain (headache)
- ❑ Mid back pain (Rt/Lt)
- ❑ Pain began several hours after accident
- ❑ Neck pain (Rt/Lt)
- ❑ Lower extremity pain (Rt/Lt)

Indicate the action taken by the patient immediately following the accident:

- ❑ Went home and rested
- ❑ Went onto normal business
- ❑ Went home and (shortly after/ later that night! the following morning) began to experience (neck mid back! low back) pain.
- ❑ Went home and later (drove/was driven) to _____Hospital.
- ❑ Patient doctored him/herself thinking the pain would go away.
- ❑ Went to physician
- ❑ Was taken to the hospital by ambulance.
- ❑ HOSPITALIZATION

Name of Hospital: _____

Indicate method of delivery to hospital:
❑ Ambulance ❑ Patient drove him/herself
❑ Driven by spouse/relative friend employer ❑ Went home and was later taken or drove to

❑Was patient seen in the emergency room? Yes No

Was the patient admitted to the hospital? Yes No

Indicate any procedures performed at the hospital (including the emergency room):
❑ Examination ❑ Stitches ❑ X-rays ❑ Physiotherapy
❑ Prescription ❑ Cervical collar ❑ Injection ❑ Wounds dressed
❑ Complete bed rest ❑Other _____

Following his/her release from the hospital the patient:
❑ Returned home and took it easy
❑ Returned home and went to bed.
❑ Returned home and returned to the emergency room after ___hours _____days.
❑ Returned to work

When did the patient first contact a physician? _____
*If the patient contacted this office first skip to last history.
❑ Within a few days ❑ Other:_____

Who was the first physician consulted? _____
Family physician
Chiropractor
Family Walk In Clinic

What was done?
- ❑ Examined
- ❑ X-rayed
- ❑ Rx
- ❑ Manipulation & P.T.
- ❑ Manipulation only

Was the patient seen elsewhere for physiotherapy? Yes No

If yes, where did the Patient receive these treatments? _____

Was the patient referred to any other physician or sent for any special diagnostic tests or examinations? ❑ No ❑ Yes (explain)_____
❑ MRI ❑ CT ❑ EMG ❑ NCS ❑ SSEP ❑ Thermography
❑ Other_____

How long was the patient under the care of his/her physician? _____

Is the patient still under the doctor's care? Yes No
*If no, when was the patient discharged? _____
*If yes, indicate the frequency of the patient's visits to the doctor_____ independent medical examination.

PAST HISTORY

Has the patient been involved in any previous accidents or injuries of any kind? Yes No
Yes - dates and details _____

Has the patient been previously treated for neck or back problems? Yes No
Yes - dates and details _____

Has the Patient been previously treated by a chiropractor? Yes No
Yes - dates and details _____

Past surgical history or any condition that could affect present condition:

Any significant medical problems? (Diabetes; heart; lungs; B/P; etc.)

Did the patient enjoy good health prior to this accident? Yes No
If No - Explain

PRESENT COMPLAINTS

What are the patient's present complaints? (begin with the most severe).

DISABILITY

Has the patient lost any time from work since the accident? Yes No
If Yes - number of days lost:_____

Is the patient still off from work? Yes No
If No - Indicate the date the Patient returned to work:_____

Is the patient working at this time? Yes No

Is the Patient working with any restrictions? If so, what?

ADDITIONAL COMMENTS