

Durham Chiropractic

Vehicle Accident Information

Patient Name _____
 Date and time of Accident _____ Location _____
 How did the accident occur _____

Vehicles

Vehicle you were in _____
 Parked Stopped or estimated speed _____ mph
 You were Driver Passenger Pedestrian
 Other vehicles involved _____
 Parked Stopped or estimated speed _____ mph
 Were you wearing a seatbelt? yes no
 Did your seat have a headrest? yes no
 Position of headrest high mid low
 Did your airbag inflate with impact? yes no
 How many people in your vehicle? _____

Impact

Road conditions Wet Dry Ice Gravel Other
 Type of collision Front Rear Side Chain-reaction
 Your vehicle hit Another vehicle Object _____
 Surprised by impact Braced for impact Foot on brake
 Head-body position before impact Left Right Straight
 Any head-body parts strike anything inside vehicle? yes no
 Was a traffic citation issued? yes no

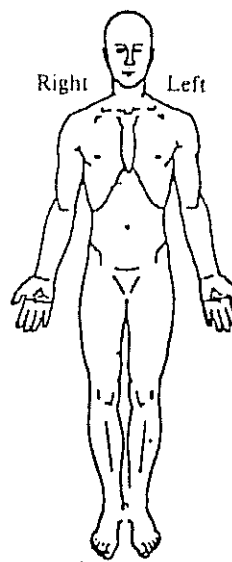
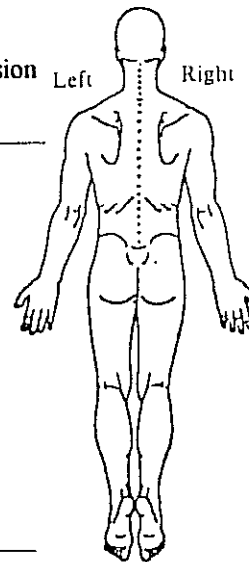
***** A police report may assist us further
 in determining the extent of your injuries**

PATIENT CONDITIONS

Immediately after the accident, were you Disoriented Unconscious; how long? _____

✓ Check any of the following symptoms you have had since your accident:

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness-tingling |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Chest-Rib pain |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stiffness, muscle tension |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Shoulder-arm pain | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Leg-foot pain | <input type="checkbox"/> Short of Breath | |



***Mark on the bodies your areas of complaint (pain, numbness, tingling etc.)**

Rate your pain, severity is on a scale from "0" best to "10" worst _____

- Type of pain Sharp Dull Throbbing
 Aching Shooting Tingling
 Cramps Burning Numbness

- How often do you have the symptoms? Constant (75-100% of time)
 Frequent. (50-75% of time)
 Intermittent (25-50% of time)
 Occasional (<25% of time)

What makes symptoms better _____

What makes symptoms worse _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Conditions are getting progressively Better Worse Same

Any delayed onset of symptoms? yes no Explain _____

Exams or treatments

Name of facility or doctor _____ Dates _____

Treatments: Exam X-rays Chiropractic Surgery MRI / CAT scan Therapy Medications

Have you been able to work since this injury? yes no How many work days missed? _____

Have you EVER had similar problems before this accident? yes no Explain _____