Motor Vehicle Personal Injury History

connect CHIROPRACTIC & WELLNESS

Patient's Name: _____ **Today's Date: _____**

Accident Details

-**Date of accident**: _____ - **Time of day**: _____

-**Number of vehicles involved in crash**:_____ - **Number of people in YOUR vehicle:** _____

-**Estimated cost of damage to YOUR vehicle**: _____ - **Totaled**? □ Yes □ No

- **Were the police notified:** □ Yes □ No - **Was a Report made?** □ Yes □ No

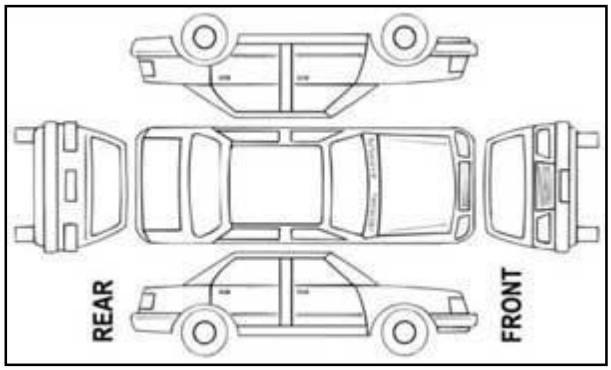
-**Location accident occurred and direction you were traveling in at time of accident**: North South East West

Street: _____ **City**: _____ **State**: _____

Were you struck by another vehicle or did you hit someone else? (Please explain how collision occurred):

_____
_____
_____
_____
_____
_____
_____

Please diagram the damage to your car that occurred during the accident



-**What kind of car were you driving?** Year: _____ Make: _____ Model: _____

-**What kind of car was the other vehicle?** Year:_____ Make: _____ Model: _____

-**Was your vehicle…?** Speeding up (~_____mph) Slowing down (~_____mph) Stopped

-**Was the other vehicle…?** Speeding up (~_____mph) Slowing down (~_____mph) Stopped

-**How did your vehicle move during the crash?** (Kept going straight, rolled over, spun around, etc) _____

_____

-**Were you aware of the oncoming collision?** □ Yes □ No

-**Where were you seated in the car** (driver, front passenger etc.)? _____

-**Were you wearing a safety belt?** □ Yes □ No **If "yes" what kind?** □Lap belt □Shoulder strap □Both

- **Did you sustain any injuries/bruises from the safety belt? (Explain):** _____

_____

_____

-**Did you have a headrest?** □ Yes □ No **If "yes" what was the height/positioning at the time of the accident?**

□Higher than head □Middle □Lower than head **AND** □Touching head □Not touching head

Your body during the accident

-**What position was your head during the accident?** (Looking left, tilted right, etc.)_____

-**What position was your torso during the accident?** (Turned right, bent forward, etc.) _____

-**What position were your hands during the accident?** (In lap, on wheel, etc.) _____

-**Did any part of your body strike any part of the car?** (Explain) _____

_____

- Loss of consciousness? □ Yes □ No *if "yes", please explain*: _____

- Were you stunned? □ Yes □ No *If "yes", how long*? _____

- Did you feel any pain? □ Yes □ No *if "yes" where?* _____

How long after the accident? _____

- Did you find bruises? □ Yes □ No *if "yes", where?* _____

- List the extent of your injuries as you know them: _____

_____

_____

- Have you previous been involved in any accidents? □ Yes □ No *if "yes", list date/type of accident/injuries etc.* _____

_____

_____

- Did you have any physical complaints BEFORE this accident? □ Yes □ No *if "yes", please explain* _____

_____

Check any symptoms that you have noticed since the accident (circle any that you are currently experiencing)

□Headache	□Low back pain	□Face flushed	□Constipation
□Skull or head pain	□Low back stiffness	□Loss of color	□Diarrhea
□Neck pain	□Hip pain	□Dizziness	□Excessive perspiration
□Neck stiffness	□Buttock pain	□Fainting	□Loss of perspiration
□Head feels too heavy	□Leg pain	□Sinus trouble	□Loss of taste
□Shoulder pain	□Leg numbness	□Loss of smell	□Cold sweats
□Shoulder stiffness	□Pins and needles in legs	□Eye stain	□Fever
□Arm pain	□Numbness in feet/toes	□Difficulty focusing	□Swelling, where: _____
□Arm Numbness	□Cold feet	□Pain behind eyes	□Pain while riding in car
□Pins and needles in arms	□Depression	□Eyes sensitive to light	□Pain/difficulty bending
□Numbness in hands/fingers	□Anxiety	□Double Vision	□ Pain/difficulty standing
□Cold hands	□Tension	□Buzzing or ringing in ears	□ Pain/difficulty sitting
□Upper back pain	□Irritability	□Loss of balance	□ Pain/difficulty walking
□Mid back pain	□Nervousness	□Palpitations	□ Pain/difficulty lifting
□Painful breathing	□Mental dullness	□Shortness of breath	□Pain while twist/turning
□Chest pain	□Loss of memory	□Digestive problems	□Difficulty rising to walk
□Rib pain	□Difficulty sleeping	□Nausea	□Pain doing occupation
□Fatigue	□Tremors	□Vomiting	□Other _____

-Did you require post-accident care or hospitalization? □ Yes □ No *if "yes", where and how did you get there?* _____

_____

- Were you examined? □ Yes □ No *if "yes" by whom*? _____

- Were X-rays taken? □ Yes □ No *if "yes" of what body parts*? _____

- What is your occupation? _____ Job duties? _____

- Have you missed work as a result of this accident? □ Yes □ No *If "yes" how many days?* _____

- Do you have any congenital (from birth) factors t relate to this/these problems? □ Yes □ No *if "yes" please describe.*

_____

_____ _____

Patient's or Legal Guardian's Signature **Date**