AUTO ACCIDENT HISTORY

Name: _____ Age: _____ Date of Birth: _____ ☐ Male ☐ Female

Date of Accident: _____ Hour: _____ ☐ AM ☐ PM Location: _____

ACCIDENT HISTORY: What type of vehicle were you in? _____

Please describe the accident in detail: _____

_____

_____

Did your body strike the interior of the vehicle? ☐ no ☐ yes If yes, Explain _____

Were you: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Pedestrian

Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side ☐ Vehicle stopped

What direction were you headed: _____ Did anyone witness the accident? ☐ yes ☐ no

Did your vehicle strike another vehicle? ☐ yes ☐ no Did their vehicle strike your vehicle? ☐ yes ☐ no

Did anyone get a ticket for the accident? ☐ yes ☐ no If yes, you or the other driver?

Were police notified? ☐ yes ☐ no Did you require hospitalization for these injuries? ☐ yes ☐ no

Have you been treated by a family doctor or E.R. doctor since the accident? ☐ yes ☐ no

Please give the name and address of the treating doctor: _____

What type of treatment did you receive? _____

Have you lost any days from work as a result of this accident? ☐ yes ☐ no

Type of employment? _____ Dates missed: _____

GENERAL SYMPTOMS Are your symptoms: ☐ Better ☐ Same ☐ Getting worse

Please Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Numbness in toes	☐ Face flushed	☐ Feet cold
☐ Neck pain	☐ Irritability	☐ Depression	☐ Buzzing in ears	☐ Hands cold
☐ Neck stiff	☐ Chest pain	☐ Fatigue	☐ Loss of balance	☐ Stomach upset
☐ Back pain	☐ Head seems to heavy	☐ Shortness of breath	☐ Fainting	☐ Constipation
☐ Nervousness	☐ Pins & needles in arms	☐ Lights bother eyes	☐ Loss of smell	☐ Cold sweats
☐ Tension	☐ Pins & needles in legs	☐ Loss of memory	☐ Loss of taste	☐ Fever
☐ Sleeping problems	☐ Numbness in fingers	☐ Ringing in ears	☐ Diarrhea	☐ _____

Symptoms other than above: _____

Please check any activity restrictions as a result of this injury?

☐ Lifting/Bending
☐ Standing
☐ Walking
☐ Rest
☐ Activity
☐ Driving/Sitting
☐ Other_____

What makes your pain feel better?

☐ Rest ☐ Nothing
☐ Analgesic Medications ☐ Activity
☐ Other_____

Review of Systems

Are you presently suffering (or have suffered in the past six months) from any of the following symptoms?

GENERAL:
- ☐ **Normal**
- ☐Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Chills
- ☐ Gain weight or loss
- ☐ Night sweats
- ☐ Other: _____

SKIN:
- ☐ **Normal**
- ☐ Rash
- ☐ Itching
- ☐ Eczema
- ☐ Hair changes
- ☐ Nail changes
- ☐ Other: _____

EYES:

☐ **Normal**	**R**	**L**
Vision Trouble	☐	☐
Pain	☐	☐
Discharge	☐	☐

☐ Other: _____

EARS:

☐ **Normal**	**R**	**L**
☐Hearing Trouble	☐	☐
☐Ringing	☐	☐
☐Pain	☐	☐

☐ Other_____

NOSE:
- ☐ **Normal**
- ☐ Pain
- ☐ Bleeding
- ☐ Absence of smell
- ☐ Other_____

MOUTH/THROAT:
- ☐ **Normal**
- ☐ Sores
- ☐ Dryness
- ☐ Other_____

NEUROLOGIC:
- ☐ **Normal**
- ☐ Headache
- ☐ Dizziness
- ☐ Convulsions
- ☐ Other_____

GLANDULAR
- ☐ **Normal**
- ☐ Hot/Cold Intolerance
- ☐ Sugar in urine
- ☐ Goiter
- ☐Tremor
- ☐ Other_____

MENTAL:
- ☐ **Normal**
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss or impairment
- ☐ Phobias
- ☐ Mood Swings
- ☐ Other_____

HEART:
- ☐ **Normal**
- ☐ Murmur
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swollen Extremities
- ☐ Other_____

LUNGS:
- ☐ **Normal**
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty Breathing
- ☐ Blue Extremities
- ☐ Other_____

BREASTS:
- ☐ **Normal**
- ☐ Lumps in breast(s)
- ☐ Redness/Itching
- ☐ Pain
- ☐ Dimpling
- ☐ Discharge
- ☐ Other_____

STOMACH/INTESTINES:
- ☐ **Normal**
- ☐Decreased Appetite
- ☐ Increased Appetite
- ☐ Abdominal
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other_____

REPRODUCTIVE/URINATION:
- ☐ **Normal**
- ☐ Inability to hold urine
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Irregular Menstruation
- ☐ Painful Menstruation
- ☐ Abnormal Vaginal Bleeding
- ☐ Impotence
- ☐ Sterility
- ☐ Other_____

2. What Are Your Habits? (Please circle)

Smoking: Never a smoker Former smoker Packs per day : <1 1-2 2-3 3-4 5+

Alcohol: Abstains Former alcoholic Glasses per day: <1 1-2 2-3 3-4 5+

Drug/Substance Use: Never Occasionally Moderately Excessive

Diet: ☐ Healthy ☐ Needs Improvement ☐ Poor

Exercise: Days Per Week 0 <1 1-2 2-3 3-4 5+

Kinds of Exercise You Do: ☐ Walking ☐ Cycling ☐ Jogging ☐ Swimming ☐ Strength Training ☐ Other_____

C. Medical History

1. Health Care: (Please Circle)

Have you been to a chiropractor? Yes No
Have you been hospitalized in the last 5 years? Yes No
Have you ever had Surgery? Yes No
Please list the dates and reasons of any prior surgeries

_____

_____

Are you currently taking any medications? Yes No
If yes please list the name and dosage of medications or attach a copy of your medications:

_____

_____

Are you allergic to any medications? Yes No

_____

Women: Are you pregnant? Yes No If yes, How many weeks? _____
Are you under the care of an OB-GYN? Yes No

2. Which of the following illnesses have you had?

☐ No Previous Illness	☐ Thyroid problems	☐ Polio	☐ Scoliosis
☐ Arthritis	☐ High Blood pressure	☐ Rheumatic Fever	☐ Prostate Trouble
☐ Asthma	☐ Low Blood Pressure	☐ Bone Fracture	☐ Mental Difficulties
☐ Sinus Trouble	☐ Heart Trouble	☐ Spinal Disc Disease	☐ Ulcer
☐ Allergies	☐ HIV/ARC	☐ Multiple Sclerosis	☐ Epilepsy
☐ Tuberculosis	☐ AIDS	☐ Kidney Trouble	☐ Diabetes Type 1 or 2

☐ Cancer (Type) _____ ☐ Other _____

3. Family Health History: (Please check all that apply)

Father: ☐ Diabetes ☐ Cardiovascular disease ☐ High Blood Pressure ☐ Stroke ☐ Headaches ☐ Neck/Back problems
☐ Arthritis ☐ Osteoporosis ☐ Cancer: Type _____ ☐Other_____

Mother: ☐ Diabetes ☐ Cardiovascular disease ☐ High Blood Pressure ☐ Stroke ☐ Headaches ☐ Neck/Back problems
☐ Arthritis ☐ Osteoporosis ☐ Cancer: Type _____ ☐ Other_____

Siblings: ☐ Diabetes ☐ Cardiovascular disease ☐ High Blood Pressure ☐ Stroke ☐ Headaches ☐ Neck/Back problems
☐ Arthritis ☐ Osteoporosis ☐ Cancer: Type _____ ☐ Other_____

Children: ☐ Diabetes ☐ Cardiovascular disease ☐ High Blood Pressure ☐ Stroke ☐ Headaches ☐ Neck/Back problems
☐ Arthritis ☐ Osteoporosis ☐ Cancer: Type _____ ☐ Other_____

D. Occupational History

1. **Job Type:** Retired Full time Student Unemployed Full time Part time Temporary Self-Employed
2. **What movements does your job require?** ☐ Bending ☐ Light to moderate lifting ☐ Stooping ☐ Walking
   ☐ Moderate to heavy lifting ☐ Turning ☐ Repetitive Hand use ☐ Other _____
3. **What is your primary position at work?** ☐ Sitting ☐ Standing ☐ Other _____
4. **Do work activities aggravate your present complaints?** Yes No

Patient's Signature: _____ **Date:** _____