Motor Vehicle Accident Information

Last Name:	Social Security No.:
First Name:	Middle:

General Information

Date of Accident:			
Location (circle one)	**Driver**		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patients Vehicle	**Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : (MPH**)**	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information for Vehicles or Objects

Impact Information: Vehicle or Object (I)

(Select one)	**Name Object :**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / Compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (II)

(Select one)	**Name Object :**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / Compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	☐ Yes / ☐ No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other :
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left Foot	☐ Right Foot	☐ Left Knee
☐ Left Hand	☐ Left Shoulder	☐ Right Shoulder	☐ Right Knee
☐ Right Arm	☐ Left Elbow	☐ Left Arm	☐ Other :
☐ Upper Front Torso	☐ Mid Torso	☐ Right Elbow	
☐ Upper Back	☐ Mid Back	☐ Lower Front Torso	
☐ Left Leg	☐ Right Leg	☐ Lower Back	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	☐ Yes	☐ No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospital:
Test:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify)
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents	☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision ☐ Other Specify:
Neck (with Movement)	☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Popping in Neck ☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ Bend Right ☐ Other Specify:
Shoulders	☐ Pain in Shoulder Joint ☐ Tension in Shoulders ☐ Muscle Spasms in Shoulder ☐ Pain Across Shoulder ☐ Can't Raise Arms Above [ ] Above Shoulder Level [ ] Over Head ☐ Other Specify:
Arms and Hands	☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold ☐ Pin & Needles in Hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength ☐ Pin & Needles in Fingers ☐ Swollen Joints in Fingers ☐ Other Specify:
Chest	☐ Chest Pain ☐ Pain Around Ribs ☐ Shortness of Breath ☐ Breast Pain ☐ Other Specify:
Abdomen	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
Mid back	☐ Sharp Stabbing ☐ Mid Pain Back ☐ Pain From Front to Back ☐ Dull Ache ☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain Between Shoulders ☐ Other Specify:
Lower Back	☐ Low Back Pain Low back pain is worse when ☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms ☐ Other Specify:
Hips, Legs & Feet	☐ Pain in Buttocks ☐ Pain and Needles in Legs ☐ Pain Down Leg ☐ Pain in Hip Joint ☐ Feet Feel Cold ☐ Swollen Feet ☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee Pain ☐ Leg Cramps ☐ Cramps in Feet ☐ Other Specify:
General	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination ☐ Cramping ☐ Irregularity Loss of Sleep : [_____] hrs per night Loss of weight : [_____]lbs Gain weight : [_____] lbs Other:

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.