ADVANCED CHIROPRACTIC

9212 Everegreen Way
Everett, WA 98204
425-353-7246

GENERAL:

NAME: _____ DATE: _____

DOB: _____ *For Office Use*: Account #: _____

Date of Accident: _____ Time of day: _____

Were you the: Driver Passenger Front Back (rt/lt side) Pedestrian

Number of people in the car: _____

Did your car strike the other: YES NO Did the other car strike you: YES NO

How many impacts where there: Where were you struck: Front Rear Lt Side Rt Side Other

What was your approximate speed: Other Vehicle: _____

What type of car were you in: Other Vehicle type: _____

Was your foot on the brake: YES NO

Road conditions: WET DRY ICY OTHER: _____

Were the police notified: YES NO

Was your car towed away: YES NO

Were you wearing a seatbelt: YES NO Shoulder strap: YES NO

Did an airbag stop your body's motion: YES NO

Does your car have a headrest: YES NO

Height/Position of headrest: SHOULDER NECK HEAD ABOVE HEAD

Were you aware the collision was going to happen: YES NO

Which direction were you looking at time of impact: Lt Rt Up Down Straight Ahead

Did your body hit anything in the vehicle: YES NO If yes,exlain: _____

Did you lose consciousness: YES NO If yes, how long: _____

What position were your hands on the steering wheel: Lt: Rt:

Please *briefly* describe the accident in your own words: _____

_____

Were you taken to the hospital: YES NO Which Hospital: _____

What type of treatment did you receive: _____

Have you seen any doctors since the accident: YES NO Who? _____

List all treatment since the motor vehicle accident: _____

_____

Please list all medications you have taken since the motor vehicle accident: _____

PREVIOUS HISTORY

Did you have any physical complaints BEFORE THE ACCIDENT: YES NO

If yes, please describe:

Have you had any previous auto accidents or any other type of physical injury (work, slip,falls) which required care from a physician: YES NO If yes, explain:

Were you released from care: YES NO

EMPLOYMENT INFORMATION

Employer Name: Job Description:

Have you missed time from work due to the accident: YES NO

How many days: Are you currently off work: YES NO

If working, describe work capacity:

CURRENT CONDITIONS

Describe how you felt:

RIGHT after the accident:

LATER that day:

The NEXT day:

PHYSICAL SYMPTOMS: Please check any symptoms you have experienced since the accident:

- ○ Headaches
- ○ Neck pain
- ○ Head Feels too heavy
- ○ TMJ pain
- ○ Shoulder pain/stiffness
- ○ Arm pain (rt/lt)
- ○ Pins/needles arm/hands (rt/lt)
- ○ Upper back
- ○ pain/stiffness
- ○ Mid back pain/stiffness
- ○ Rib pain
- ○ Lower back pain/stiffness
- ○ Hip pain
- ○ Leg pain (rt/lt)
- ○ Pin/needles legs (rt/lt)
- ○ Numbness in toes/feet
- ○ Cold feet
- ○ Cold hands
- ○ Painful Breathing
- ○ Depression
- ○ Anxiety
- ○ Tension
- ○ Irritability
- ○ Nervousness
- ○ Mental dullness
- ○ Loss of memory
- ○ Difficulty sleeping
- ○ Fatigue
- ○ Difficulty focusing
- ○ Pain behind eyes
- ○ Eye sensitive to light
- ○ Buzzing/ringing in ears
- ○ Loss of balance
- ○ Digestive problems
- ○ Nausea/vomiting

Difficulty/pain when:

- ○ Riding in a car
- ○ Bending
- ○ Standing
- ○ Sitting
- ○ Walking
- ○ Rising to walk
- ○ Lifting
- ○ Twisting
- ○ House chores
- ○ Coughing
- ○ Sneezing
- ○ Driving
- ○ Other: _____

Do you notice any activity restrictions as a result of this injury: YES NO

If yes, please describe in detail:

PRINT NAME

SIGNATURE DATE *Account #*