ECKERT CHIROPRACTIC

AUTOMOBILE ACCIDENT HISTORY

Patient Name_____ Todays Date_____ Date of Injury_____

Was the accident on the job? ◯Yes ◯No

Where were you seated in the vehicle?_____

Name of person driving the vehicle_____

Your Vehicle (year, make, model)_____

Your estimated speed at the moment of the accident_____ ◯Stopped ◯Slowing ◯Accelerating

If stopped, was your foot on the brake ◯Yes ◯No

Other Vehicle (year, make, model)_____

Estimated speed of the other vehicle at moment of impact_____ ◯Stopped ◯Slowing ◯Accelerating

Road conditions at the time of the accident:

◯Dry ◯Damp ◯Wet ◯Snow ◯Ice

Time of day:

◯Daylight ◯Dawn ◯Dusk ◯Dark

Head restraints, Seat backs:

How far is the top of the headrest or seatback from the back of your head?_____ inches

If adjustable, was the position of the headrest altered by the accident? ◯Yes ◯No

Was the seat back adjustment altered by the accident? ◯Yes ◯No

Was the seat boken ◯Yes ◯No

Seat belts and Air bags:

Were you wearing a seatbelt? ◯Yes ◯No ◯Don't know

What type? ◯Lap seat belt ◯Shoulder seat belt ◯Shoulder-lap seat belt

Did your air bag deploy? ◯Yes ◯No

If yes, were you struck? ◯Yes ◯No Where?_____

Head and Body position:

Which way was your body pointed at the point of impact? ◯Straight ◯Right ◯Left

Which way was your head pointed at the point of impact? ◯Straight ◯Right ◯Left

_____ _____

Patient signature Date

Patient Name

ACCIDENT DIAGRAM

In the space below, please describe, to the best of your knowledge, what happened during this accident

DURING THE CRASH:

Position of hands: ○ One on wheel ○ Two on wheel ○ N/A

Did you strike any parts of the vehicle? ○ Yes ○ No

If yes, please describe

Did vehicle strike any objects after the crash? ○ Yes ○ No

If yes, please describe

Were you aware or surprised of the approaching collision? ○ Aware ○ Surprised

Were you wearing a hat or glasses? ○ Yes ○ No

If yes, were they still on after the crash ○ Yes ○ No

Did you lose consciousness (black out) upon impact? ○ Yes How long? ○ No

Did you experience a flash of light or explosion in your head? ○ Yes ○ No

AFTER THE CRASH

Did you become : ○ Confused ○ Disoriented ○ Light headed ○ Dizzy
○ Nauseated ○ Blurred vision ○ Ring/Buzz in ears

If you still have any of those symptoms, which ones:

Are you currently suffering from any of the following:

○ Restlessness ○ Irritable ○ Difficulty concentrating ○ Difficulty with memory
○ Sleeplessness ○ Forgetful ○ Reduced tolerance to heat ○ Reduced tolerance to alcohol

Did the police come to the accident scene? ○ Yes ○ No Is there a report? ○ Yes ○ No

Patient signature Date

Patient Name

HOSPITAL

Did you go to the hospital? ◯ Yes ◯ No

How did you get to the hospital? _____

Name and city of hospital _____

Name of emergency room doctor _____

What parts of body were x-rayed at the hospital? _____

How long did you stay in the hospital? _____

What did the hospital do for your injuries? ◯ Cervical collar ◯ Ice pack

◯ Medications _____ ◯ Follow up instructions _____

ORIGINAL COMPLAINTS- If the accident is more than one month old

If accident was within the last month, skip this section and go to the next page.

1) _____

Date when symptom f rst appeared _____

How often did you experience the symptoms?

◯ Constant 100% ◯ Frequent 75%

◯ Intermittent 50% ◯ Occasional 25% ◯ Rare 10%

What made symptom increase? _____

What gave relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where did the pain radiate to? _____

Rate the symptoms from 1 to 10 (10 = worst)_____

2) _____

Date when symptom f rst appeared _____

How often did you experience the symptoms?

◯ Constant 100% ◯ Frequent 75%

◯ Intermittent 50% ◯ Occasional 25% ◯ Rare 10%

What made symptom increase? _____

What gave relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where did the pain radiate to? _____

Rate the symptoms from 1 to 10 (10 = worst)_____

3) _____

Date when symptom f rst appeared _____

How often did you experience the symptoms?

◯ Constant 100% ◯ Frequent 75%

◯ Intermittent 50% ◯ Occasional 25% ◯ Rare 10%

What made symptom increase? _____

What gave relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where did the pain radiate to? _____

Rate the symptoms from 1 to 10 (10 = worst)_____

4) _____

Date when symptom f rst appeared _____

How often did you experience the symptoms?

◯ Constant 100% ◯ Frequent 75%

◯ Intermittent 50% ◯ Occasional 25% ◯ Rare 10%

What made symptom increase? _____

What gave relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where did the pain radiate to? _____

Rate the symptoms from 1 to 10 (10 = worst)_____

_____ _____

Patient signature Date

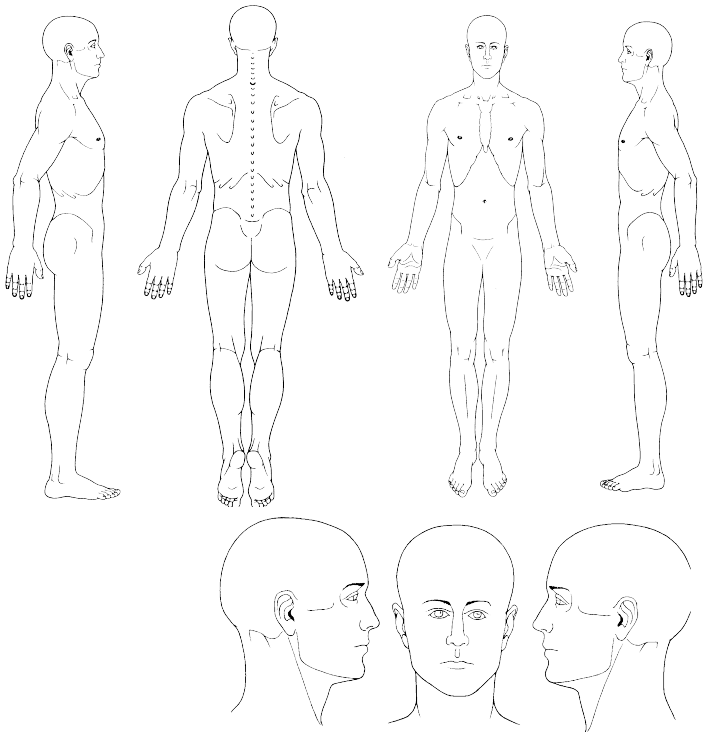
Patient Name

CURRENT COMPLAINTS -

Please list, in detail, all current symptoms / complaints in order of severity

1) _____

Please mark your areas of pain on the f gures below



Date when symptom f rst appeared _____

How often do you experience the symptoms?

◯ Constant 76-100% ◯ Frequent 51-75%

◯ Intermittent 26-50% ◯ Occasional 11-25% ◯ Rare 10%

Describe any recently related accident or fall _____

_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0510 _____ _____

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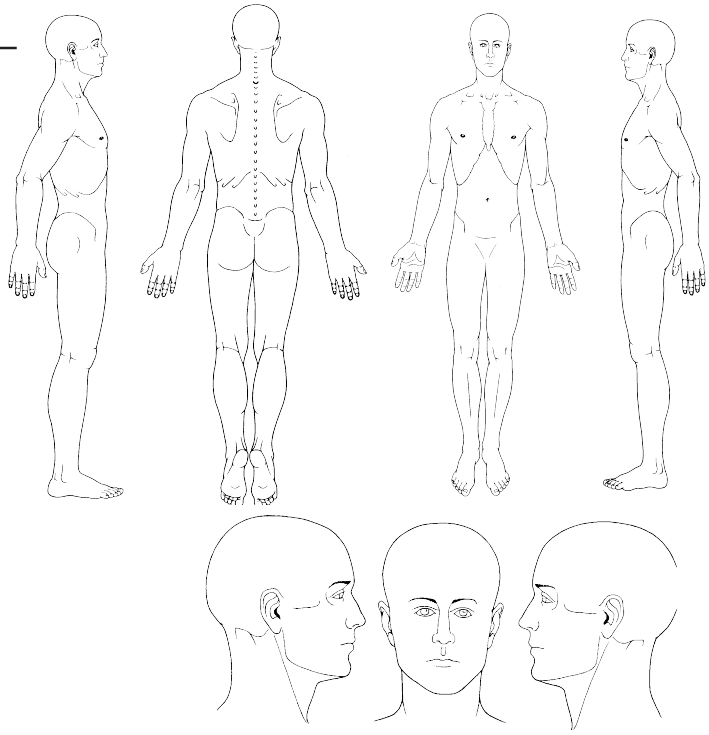
2) _____



Date when symptom f rst appeared _____

How often do you experience the symptoms?

◯ Constant 76-100% ◯ Frequent 51-75%

◯ Intermittent 26-50% ◯ Occasional 11-25% ◯ Rare 10%

Describe any recently related accident or fall _____

_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0510 _____ _____

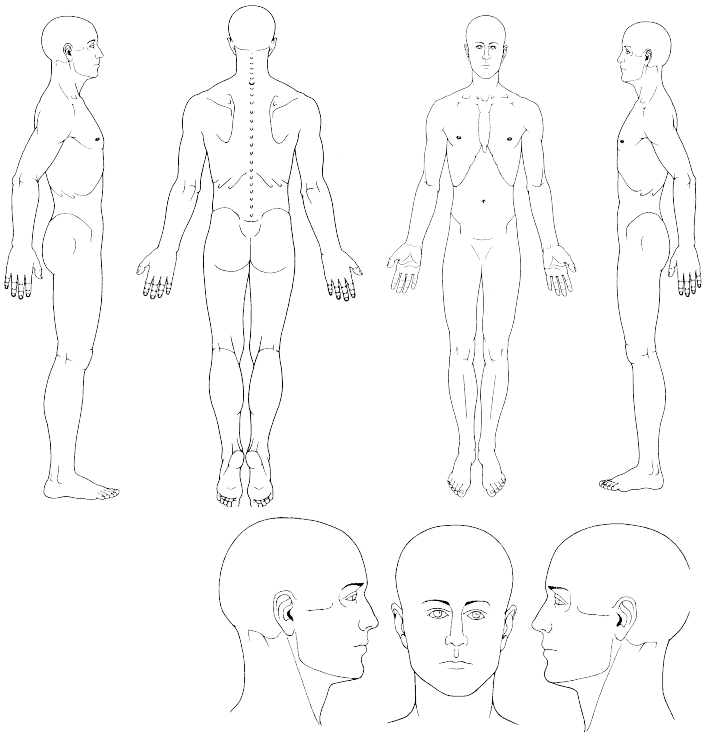
_____ _____

Patient signature Date

CURRENT COMPLAINTS Continued

Patient Name _____

Please mark your areas of pain on the f gures below



3) _____

Date when symptom f rst appeared _____

How often do you experience the symptoms?

◯ Constant 76-100% ◯ Frequent 51-75%

◯ Intermittent 26-50% ◯ Occasional 11-25 ◯ Rare 10%

Describe any recently related accident or fall _____

_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

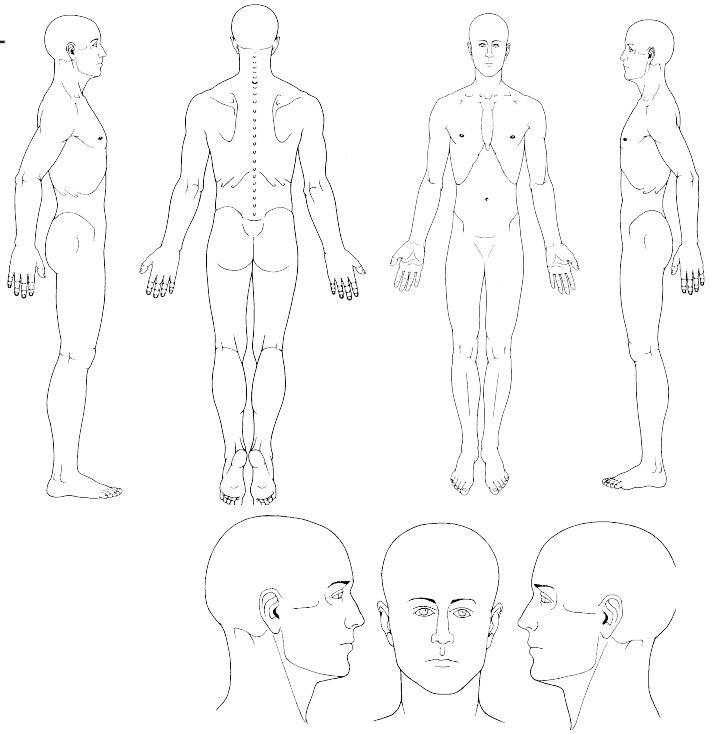
◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0510 _____ _____



4) _____

Date when symptom f rst appeared _____

How often do you experience the symptoms?

◯ Constant 76-100% ◯ Frequent 51-75%

◯ Intermittent 26-50% ◯ Occasional 11-25% ◯ Rare 10%

Describe any recently related accident or fall _____

_____

_____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0510 _____ _____

_____ _____

Patient Signature Date

PLEASE LIST ALL PREVIOUS TREATMENTS FOR CONDITIONS RELATED TO THIS ACCIDENT

1) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

2) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

3) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

4) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

5) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

6) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

7) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

_____
Patient Signature

_____
Date

PAST HEALTH HISTORY

Patient Name _____

PLEASE LIST ALL SUGERGIES YOU HAVE HAD

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

PLEASE LIST ALL PREVIOUS FRACTURES AND DISLOCATIONS

What _____ When _____

What _____ When _____

Remarks _____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

PLEASE LIST ANY PRIOR HISTORY OF CURRENT COMPLAINTS

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

PLEASE LIST ALL PRIOR ACCIDENTS, ASSOCIATED COMPLAINT AND TREATMENTS

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

OCCUPATIONAL INFORMATION

Job Involves:

○Sitting ○Standing How long_____ ○Desk ○Counter ○ Other_____

○Lifting How much weight_____ ○Bending ○Stooping ○Twisting ○Turning

Type of shoes ○High heels ○Boots ○Arch supports ○Other _____

How long do you speak on the telephone each day _____ ○Traditional telephone receiver ○Headset

Physical activity at work ○Sedentary ○Light manual labor ○Manual labor ○Heavy manual labor

Do any of your work activities aggravate your present main complaints? Please describe _____

_____

_____ _____

Patient Signature Date

Patient Name _____

HEALTH HABITS: How much per day or week?

Tea, coffee _____ Liqour _____ Tobacco _____ Sugar, candy, ice cream _____

Exercise: 1)Type _____ Frequency _____ 2) Type _____ Frequency _____

3) Type _____ Frequency _____ 4) Type _____ Frequency _____

Sleep: Hours per night _____ Type of mattress _____ Naps _____

Do you sleep on your ○ Back ○ Side ○ Stomach

Please describe your sleep _____

Special diets _____

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD

○ HIV Positive	○ Goiter	○ Tuberculosis	○ Diabetes	○ Malaria	○ Pneumonia
○ Anemia	○ Gout	○ Typhoid Fever	○ Diptheria	○ Measles	○ Polio
○ Appendicitis	○ Heart Disease	○ Ulcers	○ Eczema	○ Miscarriage	○ Rheumatic Fever
○ Arteriosclerosis	○ Herpes	○ Venerial Infection	○ Emphysema	○ Multiple Sclerosis	○ Scarlet Fever
○ Arthritis	○ Inf uenza	○ Whooping Cough	○ Epilepsy	○ Mumps	○ Stroke
○ Cancer	○ Lumbago	○ Cold Sores	○ Hypersensitivity	○ Pleurisy	○ Other _____
○ Tuberculosis	○ Small Pox	○ Allergies	○ Asthma	○ Chicken Pox	_____

DISABILITY

Do you have a permenant disability rating? _____ Location _____ Date received _____

Rating Percentage _____

X-RAY CONFIRMATION- FEMALES

This is to conf rm that I have been advised by this off ce that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Signed Date

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge

_____ _____

Patient Signature Date

DOCTORS NOTES:

ACTIONS TAKEN ON THIS VISIT

○ Examination/TX _____

○ X-rays _____

○ Disability _____

○ Work restriction _____

○ Supplies _____

○ Tests/Referrals _____