Name:
DOB:

Auto Injury History Form

Please fill out completely & initial the bottom of each page. The questions on these forms will help us to diagnose you problem and better assist you in your claim.

General Information:
Date of Injury:________________
Approximate time of Injury:________________
Accident History Prior to Crash:
Any previous pain/problems in area injured? (Please answer. If so, explain.)____

Was the accident on the job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Other:____________
Vehicle driven by:________________________________
Your vehicle (year, make, model):________________________________
Your estimated speed at moment of accident:________________________
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model):________________________________
Other vehicle estimated speed at moment of accident:________________________
Road Conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other:__________
Please indicate location of head restraint at the time of the accident:
☐ At the top of the back of my neck ☐ At the middle of the back of my head
☐ At the bottom of the back of my head ☐ At the back of my neck
☐ Below my neck at shoulders ☐ No head restraint
☐ Head restraint/seat are attached (Integral type)
If adjustable, was the position altered by the accident? ☐ Yes ☐ No
Was it pushed down? ☐ Yes ☐ No
Was the seat back adjustment altered by the accident? ☐ Yes ☐ No
Did the seat move forward or backwards? ☐ Yes ☐ No
Do you have your seat reclined when you drive?
☐ A little ☐ Some ☐ A lot
Was the seat broken? ☐ Yes ☐ No
Was your seatbelt broken? ☐ Yes ☐ No
Lap belt/Shoulder belt: ☐ Wearing ☐ Not Wearing
Were you aware of the impending crash? ☐ Yes ☐ No
Did your air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Straight ☐ Forward lean ☐ Other__________
Head position: Which way were you looking upon impact?
☐ Straight forward ☐ Up ☐ Down
☐ Left ☐ Right
Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A
Brakes applied? ☐ Yes ☐ No
Brief accident description:
____
____
____
____

Please Turn Over

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Accident Diagram: Please describe street names & direction you were heading. Draw an "x" where each vehicle sustained the most damage. A square represents your car (#1) and an oval represents the other car (#2). Use arrows to show your direction.

Accident History

Did you strike any parts of the vehicle? ☐ Yes ☐ No
If yes, describe:
____
____
____

Did your vehicle strike any objects after crash? ☐ Yes ☐ No
If yes, describe:
____
____
____

Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long?______________________________

Accident History <u>After the Crash</u>:

Estimated property damage to your vehicle:______________________________
Estimated damage to other vehicle:______________________________
Were the police on-scene? ☐ Yes ☐ No
If yes, was a report made? ☐ Yes ☐ No

Symptoms: ☐ Head ache ☐ Dizziness
☐ Nausea ☐ Confusion/disorientation
☐ Neck pain ☐ Back pain
☐ Arm/leg pain ☐ Other:_______________

Please describe when you noticed each symptom after the crash.
____
____
____

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Where did you go after accident? ☐ Home ☐ Work ☐ Hospital
☐ Other:________________

Mode of transportation:____
Private Doctor:____
If you have not seen a doctor for this injury within the first month after accident, please indicate reason(s):

☐ Did not notice any pain ☐ Time Conflict
☐ Unable to schedule appointment ☐ No Transportation
☐ I thought the pain would disappear ☐ I had no insurance money
☐ I self treated with over-the-counter drugs ☐ Took hot showers, used ice/heat
☐ Other:________________________

Have you been unable to work since the accident? ☐ Yes ☐ No
If yes, were you off work (please list dates):____

Confidential Auto Case History

Please fill in this questionnaire COMPLETELY. If a section does not apply to you, simply cross it out. This confidential history will be a part of your permanent records.

What are your major complaints in order of intensity? (#1 most bothersome)
1)________________ 2)________________ 3)________________ 4)________________
Please place an x on the lines below and write the area of pain in each below and the frequency of your pain.
Sample Only:

0--------------x------------------------x----------------------------x-------------------10

No Pain	Neck	Left Leg	Low Back	Extreme Pain
	Constant	Frequent	Intermittent/Occasional	

Indicate the severity of your symptoms. (10 is the worst possible pain that can be felt)
How bad are your symptoms now?

0---10
No Pain Extreme Pain

How bad are your symptoms most of the time?

0---10
No Pain Extreme Pain

How bad have they been in the past?

0---10

No Pain Extreme Pain

When during the day are your symptoms: (Ex: Morning, Evening)
Worse____
Better____
Please rank in order of intensity which movements/positions make each area worse:
(Sample: 1. Neck –reading, turning head; 2. Low back – sitting, walking)
1.____

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Name:
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2.____
4.____
Please describe which movements/positions make each area better: (Sample: Neck -- exercises)

____
____

Functional Information

Has pain interfered with your social life, hobbies, or sexual ability?
☐Yes ☐ No If so, how?________________
How many hours a night do you sleep since the injury?____________________
Before your pain/injury?____________________
Do you know why?______________________________
Does pain frequently awake you? ☐Yes ☐No
If yes, about how many times would you wake up per night?________________
Before your pain how many times would you wake up per night?______________
Sleep position: ☐Back ☐Stomach ☐Right side ☐ Left side
At any one time, how many hours can you:
Sit___hrs. Walk___hrs. Stand___hrs. Bend___hrs.
Is this condition interfering with: (Please circle) work, sleep or other daily routines such as reading, housecleaning, driving, sitting, dressing, etc.? Discuss what areas of your body you have more problems with due to each activity.

____
____

Past Injury History

Have you had any prior on-the-job injuries? ☐Yes ☐No
Have you had any automobile accident injuries? ☐Yes ☐No
If disabled, (as worker/student/homemaker), date last worked?________________
If disabled, have you tried to return to work? ☐Yes ☐No
What day?________ ☐Part Time ☐Full Time
Have you received disability income related to this condition?
☐ Yes, receive now ☐ Yes, in the past ☐No, never
Is this a work related or auto accident injury?
☐ Auto Accident ☐ Work Accident ☐Neither

Social History

Work Status: ☐Full Time ☐ Part Time ☐Student ☐Disabled ☐Unemployed ☐Retired
In a typical workday, your job requires that you: (8hrs total)
Sit___hrs. Walk___hrs. Stand___hrs. Bend___hrs.
Physical Work: ☐Heavy ☐Moderate ☐Light Hours/day:____________
Number of children:__________ Ages:______________
What are your hobbies / organizations in which you participate? (To determine if your extracurricular activities could be making your condition worse)
1)________________________ 2)________________________
3)________________________ 4)________________________
Exercise: ☐Heavy ☐ Moderate ☐Light Hours/day:__________
Type:________________
Have you recently lost or gained weight? ☐Yes ☐No If so how much?__________
Writing Hand: (Please circle) Left Right Ambidextrous

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Results of Treatment

What are the results you hope for:

	Pain reduction
	Increased recreation
	Improved emotional well-being
	Return to work
	Elimination of drugs
	Better daily function
	Other:_________________

What do you hope will be the results of this evaluation:

	Medical Diagnosis
	Recommendation for rehabilitation
	Recommendation for surgery
	Recommendation for treatment
	Determine the existence of a disability
	Other:___________________

Release of Information:

The physician may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician or the patient or to a family member or employer of the patient for all part or part of the physician charges, including but not limited to, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.
As a courtesy, we may send your primary care physician reports about your treatment with our office. By signing below I authorize my records to be sent to my primary care physician and the release of any medical or other information necessary to process my claims. Our office may photography you on your first visit for identification purposes. Your photography may be sent to your insurance company with your medical records. Any other use will require your consent.

Consent for Treatment:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician.

I understand that rehabilitation medicine occasionally aggravates an existing condition and that this may be possible in respect to my condition. I understand treatments rendered by Adkins Chiropractic P.C. are intended to aid in the reduction of my pain and to allow as full a recovery as possible and are not intended to aggravate an existing condition or cause a new one to occur.

I have carefully completed and reviewed this form to the best of my knowledge.

____ ______________________

Signature Date

____

Relationship to patient (if not self)

Please Turn Over