DISCOVER CHIROPRACTIC

Name: _____ Today's Date: _____

Auto Related Injury Reports

Date of Accident: _____ Time: _____ □ AM □ PM Location: _____
Did you report the accident? □ Yes □ No If yes, to whom? _____
Describe the accident: _____
_____
_____

Make and year of your vehicle: _____ Was your car moving? □ Yes □ No If yes, how fast? _____
Describe the amount of vehicular damage: _____
Cost of the damage? _____ How many vehicles were involved? _____
Models and years of the other vehicle(s)? _____
Was the other vehicle moving? □ Yes □ No If yes, how fast? _____
Were you the: □ Driver □ Passenger Position: □ Front Left □ Front Right □ Rear Left □ Rear Right
Was the impact from the: □ Front Left □ Front Right □ Right side □ Left side □ Rear Left □ Rear Right
Did you see the accident coming? □ Yes □ No At the time of impact, were you looking: □ Right □ Left □ Straight
Were your hands on the steering wheel? □ Yes □ No Was your foot on the brake? □ Yes □ No
Did your seat have a headrest? □ Yes □ No How was it positioned relative to your head? □ Above □ Level □ Below
Were you braced at the time of impact? □ Yes □ No The road conditions were: □ Dry □ Wet □ Snow/Ice
Were you wearing a seatbelt? □ Yes □ No If yes was it a □ Lap belt only □ Lap/Shoulder belt combination
Did your airbag deploy? □ Yes □ No Was your vehicle towed from the scene? □ Yes □ No
Did you strike anything in the car? □ Yes □ No If yes, please specify: _____
□ Head □ Face □ Chest □ Knee □ Shoulder □ Hand □ Foot □ Steering wheel □ Dashboard □ Windshield □ Door
Who else was in the car? _____
How did you feel immediately following the accident? _____
Were you unconscious after the accident □ Yes □ No If yes, how long? _____
What hurt the following day? _____
What hurt a week later (if applicable), please explain? _____

Did you visit an emergency center after the accident? □ Yes □ No If yes, which one? _____
When? _____ By? □ Ambulance □ Drove self □ Friend/Family Who was the attending doctor? _____
Were X-rays taken? □ Yes □ No Were you given a diagnosis? _____
What treatment was given, if any? _____
Are you on any medications? □ Yes □ No If yes, please list: _____ Dosage: _____
Were you released the same day? □ Yes □ No Were you given home care? □ Yes □ No _____
Since the accident have you seen any other doctors for injuries related to the accident? □ Yes □ No
Since the accident, have you had any additional traumas, falls, injuries or aggravations □ Yes □ No
Have you been in an auto accident previously? _____

Discover Chiropractic
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www.discoverbendchiro.com

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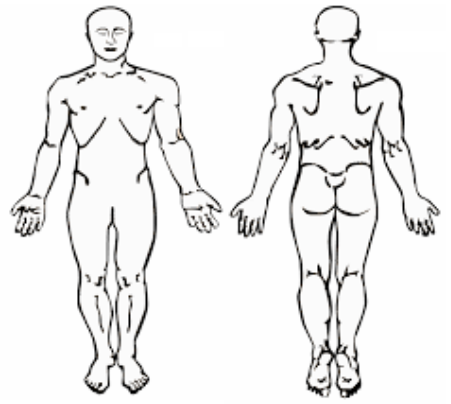
Please put a check by any symptoms you have noticed since the accident:

□ Headaches	□ Chest pain	□ Dizziness	□ Fainting	□ Abdominal Cramping
□ Head seems heavy	□ Leg pain/tingling	□ Blurred vision	□ Palpitations	□ Heartburn
□ Neck pain	□ Numbness in toes	□ Vision problems	□ Indigestion	□ Loss of smell/taste
□ Neck stiffness	□ Cold feet	□ Light sensitivity	□ Gas/bloating	□ Difficult urination
□ Pain between shoulder blades	□ Walking problems	□ Loss of concentration	□ Poor appetite	□ Painful urination
	□ Hip pain	□ Depression/confusion	□ Vomiting	□ Excessive thirst
□ Cold hands	□ Leg pain	□ Anxiety/nervousness	□ Diarrhea	□ Discolored urine
□ Numbness in fingers	□ Sleep disturbance	□ Energy loss/fatigue	□ Elbow pain	□ Hemorrhoids
□ Arm pain/tingling	□ Irritability	□ Tired AM/PM	□ Wrist pain	□ Black/bloody stools
□ Mid back pain	□ Allergies	□ Weakness	□ Hand pain	□ Weight trouble
□ Low back pain	□ Stuffed nose/sinus	□ Buzzing/ringing ears	□ Knee pain	□ Menstrual irregularity
□ Short breath	□ Sore throat	□ Ear ache	□ Ankle pain	□ Menstrual cramping
□ Cold sweats	□ Dental Problems	□ Hearing difficulty	□ Foot pain	□ Poor circulation
□ Difficulty chewing	□ Clicking Jaw	□ Constipation	□ Fever	□ Irregular heartbeat
□ Heart problems	□ Blood pressure issues	□ Bladder trouble	□ Liver trouble	□ Gall bladder trouble
□ Varicose veins	□ Ankle swelling	□ Prostate/sexual issue	□ Other	□ Frequent nausea

Please rate your ability to perform the following activities following the accident on a **scale from 0-10**, *where (0) is the complete inability to perform the activity, and (10) is the ability to perform the same as prior to the accident*.

___ Coughing/sneezing
___ Getting in/out of car
___ Turning over in bed
___ Walking short distance
___ Standing more than 1 hour
___ Sexual activity
___ Lying on side w/ knee bent
___ Lying flat on stomach
___ Bending over forward
___ Sitting at table
___ Other:
___ Pushing
___ Lying on back
___ Kneeling
___ Balancing
___ Dressing self
___ Sleeping
___ Stooping
___ Gripping
___ Pulling
___ Reaching
___ Twisting

Shade any areas of pain or discomfort you have experienced since the accident



Any time from work as a result of injuries from the accident? □ Yes □ No List dates: from _____ to _____
Are work duties restricted due to the accident □ Yes □ No If yes, how: _____
Insurance companies involved: _____
Name of the driver of the auto you were in: _____ Phone: _____
His/her insurance carrier: _____ Phone: _____ Policy #: _____
Name of the driver of the other vehicle: _____ Address: _____
Phone: _____ His/her insurance carrier: _____ Address: _____
Phone: _____ Policy #: _____ Have you contacted the insurance adjustor/representative on this claim? □ Yes □ No If yes, name: _____ Attorney representation: _____

Patients Signature _____ Date _____

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