MEMORIAL DRIVE CHIROPRACTIC & MASSAGE
Live Life Better

#213, 5271 Memorial Drive SE
Calgary, AB T2A 4V1
T: 403 273-0203 F: 403 453-0211

Name_____ Date_____

PERSONAL INJURY – PATIENT DATA FORM

Date of Accident:_____ Time:_____ AM / PM

Driver of vehicle: _____ Where were you seated?:_____

Who owns the vehicle?: _____ Year and model of car:_____

What was the approximate damage done to the vehicle: $_____

Visibility at time of accident: poor / fair / good / other:_____

Road conditions at time of accident: icy / rainy and wet / clear / dark / other (describe):_____

Where was your car struck? Right / Left / Rear / Front / Side / other:_____

Type of accident: ☐ head-on collision ☐ broad side collision ☐ rear-end collision
☐ front impact, rear-ended car in front
☐ non-collision: (describe)_____

Describe in your own words what happened to you upon impact:_____

_____

Did you see the accident coming: Yes / No
Did you brace for impact: Yes / No
Were seat belts worn: Yes / No
Were shoulder harnesses worn: Yes / No
Does your car have headrests: Yes / No

If yes, what was the position of those headrests compared to your head before the accident:
☐ top of headrest even with bottom of head
☐ top of headrest even with top of head
☐ top of headrest even with middle of neck

Was the car braking: Yes / No

Was the car moving at the time of the accident: Yes / No

If yes, how fast would you estimate you were going: _____k.p.h. (estimate)

How fast was the other car traveling: _____k.p.h. (estimate)

Head/body position at time of impact:
☐ head turned to left/right
☐ head looking back
☐ head straight forward
☐ body straight in sitting position
☐ body rotated left / right
☐ other: _____

At the time of accident, recall what parts of your head or body hit what parts on the inside of the car:_____

_____

As a result of the accident you were: ☐ rendered unconscious ☐ dazed, circumstances vague ☐ other (describe):

_____

Could you move all parts of your body?: Yes / No If no, what parts and why:_____

_____

Were you able to get out of the car and walk unaided?: Yes / No If no, why not:_____

_____

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What bleeding cuts did you get from this accident?:_____

What bruises did you get from this accident?:_____

Please describe how you felt immediately after the accident (be specific):_____

_____

Later that day _____, night_____

The next day_____, days_____

Check symptoms apparent since the accident:

☐ headache	☐ loss of smell	☐ numbness in fingers
☐ neck pain/stiffness	☐ loss of taste	☐ cold hands
☐ mid back pain	☐ loss of memory	☐ cold feet
☐ low back pain	☐ fatigue	☐ diarrhea
☐ eyes sensitive to light	☐ tension	☐ constipation
☐ pain behind eyes	☐ shortness of breath	☐ chest pain
☐ dizziness	☐ irritability	☐ nervousness
☐ fainting	☐ depression	☐ cold sweats
☐ ringing/buzzing ears	☐ sleeping problems	☐ anxious
☐ loss of balance	☐ numbness in toes	☐ other:_____

Occupation:_____ Employer: _____

Have you missed time from work: Yes / No If YES,

☐ Full time off work from _____ to _____
☐ Part time off work from _____ to _____
☐ Have been unable to work since accident

Did you go to seek medical help immediately / soon after the accident: Yes / No

If yes, how did you get there: ☐ someone else drove me ☐ ambulance
☐ drove own car ☐ police
☐ other:_____

FIRST DOCTOR/HOSPITAL/CLINIC seen:_____ Date_____
Were you examined?: Yes / No Were x-rays taken?: Yes / No

If yes, what body parts?:_____

What treatment was given to you: ☐ bed rest ☐ brace ☐ physiotherapy ☐ adjustments
☐ drugs ☐ other:_____

What benefits did you receive from the treatments:_____

_____

Date of last treatment:_____

SECOND DOCTOR/HOSPITAL/CLINIC seen:_____ Date_____

Were you examined?: Yes / No Were x-rays taken?: Yes / No

If yes, what body parts?:_____

What treatment was given to you: ☐ bed rest ☐ brace ☐ physiotherapy ☐ adjustments
☐ drugs ☐ other:_____

What benefits did you receive from the treatments:_____

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Date of last treatment:_____

Did you have any physical complaints JUST BEFORE the accident: Yes / No

If yes, please describe in detail:_____

_____

PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now:

Yes / No If yes, please explain(briefly include past falls, injuries, accidents, operations, etc.):

_____

_____

Do you notice any activities of your home daily routines are different now than from before the accident: Yes / No If yes, please list them as:

Those that you are unable to do:_____

Those that are painful to do:_____

Those that are difficult to do:_____

Please draw a diagram to show how the accident occurred:

Do you have an attorney on this case: Yes / No

If yes, who: Lawyer's Name_____ Firm Name:_____

Address:_____

City:_____ Province:_____ Postal Code:_____

_____ X_____

Print Name Signature

_____ _____

Witness Date