DENN CHIROPRACTIC--AUTOMOBILE ACCIDENT HISTORY FORM

Patient Name: ____ **Date:**_________________________

Address:____

City:__________________________________ **State:**_____ **Zip:**____________ **SS#:**_______________________

Driver's License #:____ **Date of Birth:**______________________

Home Phone:____________________________________ **Cell Phone:**________________________________

Insurance Company:____

Claim Number:_____________________________________ **Claim Representative:**_____________________________

ACCIDENT HISTORY

Date of Accident:________________________ **Time of Accident:**____________________ **AM / PM**

Please describe how the accident occurred:____

____

____

History of Accident: Driver / Passenger / Pedestrian **If Passenger?: Front / Back**
Left / Middle / Right

Patient's Vehicle Type:______________________________ **2nd Vehicle type:**__________________________________

Road Conditions: Dry / Icy / Wet / Clear / Foggy / Dark / Snowy

Road Type: Dirt / Asphalt / Gravel **Were you aware of the accident: Yes / No**

Were you wearing a seatbelt?: Yes / No **Does your car have an airbag?: Yes / No**
Did airbag deploy?: Yes / No

Does your car have a headrest?: Yes / No **Head position?: straight / Left / Right**
Level / Up / Down

Was your car braking?: Yes / No **Were you moving?: Yes / No** **How fast?:**_____________

Was the other vehicle braking?: Yes / No **Were they moving?: Yes / No** **How fast?:** ____________

Initial Impact: Hit by another vehicle / Hit another vehicle / Hit an object / Hit an object
(Where): Front / Front-Right / Front-Left / Left / Right / Right-Rear / Left Rear / Rear

Were you thrown in/out of the car?: Yes / No **If yes, Forward / backward / Right / Left**

Did any part of your body hit anything?: Head / Chest / Shoulders / Knees / Hips / Feet

If Yes, What did it hit?: **Windshield / Rear view window / Steering wheel / Dashboard**
Back of front seat / Side window/door / Another person

Were you dazed? Yes / No If yes, for how long? ______________________________________

Where did you go after the accident? Home / Hospital / Friends House / Parents House

If you went to the hospital, which one? ____

What was done at the hospital? Exam / Medications / X-rays / MRI / History / CT scan

VEHICLE DAMAGE

Your vehicle: Totaled / Significant Damage / Light Damage / No Damage

Other vehicle: Totaled / Significant Damage / Light Damage / No Damage

Third vehicle: Totaled / Significant Damage / Light Damage / No Damage

Was a citation given at the accident? Yes / No Given to whom: ____

CURRENT SYMPTOMS

Please describe your current symptoms:____

____

Type of pain:
___dull ___sharp ___stabbing
___achy ___burning ___numbness
___shooting ___tingling ___radiating

How often do you have your symptoms:
___constantly ___frequently
___occasionally ___intermittent

Are your symptoms changing?
___better ___same ___worse

Have you had these symptoms before? Yes / No

Please list anything that aggravates your symptoms:

____

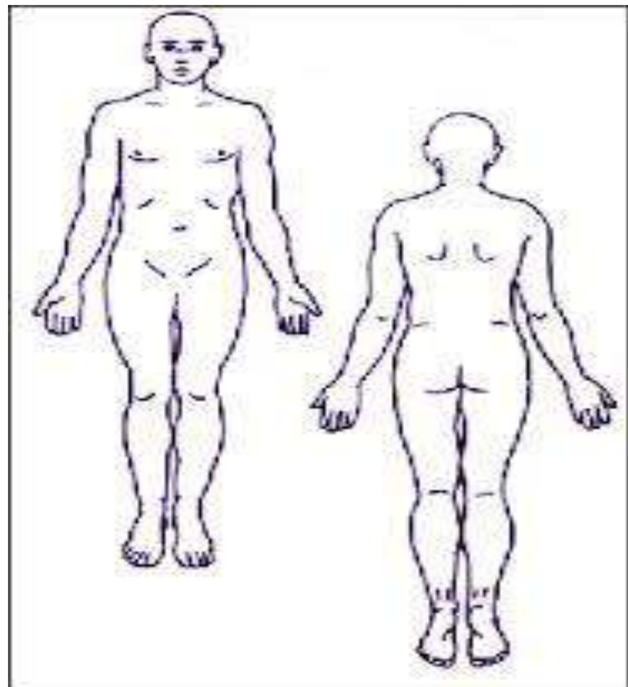
____

Please list anything that relieves your symptoms:

____

____

Please circle the areas of complaints:



Please rate your complaints based on this pain scale: **No pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst pain**