DENN CHIROPRACTIC
Healing the Body From Within

AUTOMOBILE ACCIDENT HISTORY

PATIENT INFORMATION:

Name: ____ Date: ____ / _____ / _______

Auto. Insurance Company: _________________________________ Insurance Phone #: ____ / _____ / _______

Insurance Company address: _______________________________ City:______________________ State: _____

Claim Number: __________________________ Claims Representative: _________________________________

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AUTO ACCIDENT INFORMATION:

Date of accident: ____ / _____ / _______ Time of accident: _____ / _____ ___AM ___PM

Please describe how the accident occurred: ____

____

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Were you the ___ **DRIVER** ___ **PASSENGER** ___ **PEDESTRIAN** If passenger? ___front ___back ___middle

What were the road conditions: ___dry ___icy ___wet ___clear ___foggy ___dark ____snowy

Were you aware of the accident?: ___Yes ___No Were you wearing a seatbelt?: ___Yes ___No

What was you head position at the time: ___straight ahead ___looking left ___looking right ___looking down

Was you car braking?: ___Yes ___No Was your car moving?: ___Yes ___No If Yes, how fast?: __________

Was the other vehicle braking?: ___Yes ___No Was their car moving?: ___Yes ___No If Yes how fast?: __________

What was the initial impact of the accident: ___hit by another vehicle ___Hit another vehicle ___hit an object

___was hit by an object ___ went off the side of the road ___slipped off the road (snow / ice)

Did you hit any part of your body in the accident?: ___Yes ___No

If Yes, please explain: ___head ___chest ___shoulders ___hips ___knees ___feet

What did you hit?: ___windshield ___rear view mirror ___steering wheel ___dashboard

___side window ___another person ___back of the front seat

Were you dazed at the time of the accident?: ___Yes ___No If Yes, for how long? ___________________________

Where did you go after the accident?: ___hospital ___ER ___home ___Parents house ___Friends house

If you went to the hospital / ER what was done?: ___Exam ___X-rays ___MRI ___CT scan ___medication given

What was the damage to your vehicle?: ___totaled ___significant damage ___light damage ___no damage ___unknown

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Are you taking any medications now for your recent injury?

___ Pain killers ___ Anxiety meds. ___ Vicodin ___ Tramadol ___ Morphine ___Advil

___ Muscle relaxers ___ Oxycodone ___ Hydrocodone ___ Fentanyl ___Acetaminophen

___ Other: ______________________________

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Please describe the type of pain you are having:

___ dull ___ achy ___ sharp ___Stiff

___ Shooting ___ Radiating ___ Burning ___ Tight

___ Numbness ___ Tingling ___ stabbing

Are your symptoms changing:

___ better ___same ___ getting worse

If worse, how long? _______________________

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How often are your current symptoms:

___ constantly (76-100%) ___frequently (51-75%)

___ occasionally (25-50%) ___ Intermittent (25% of less)

___ coming and going (with certain actions / movements

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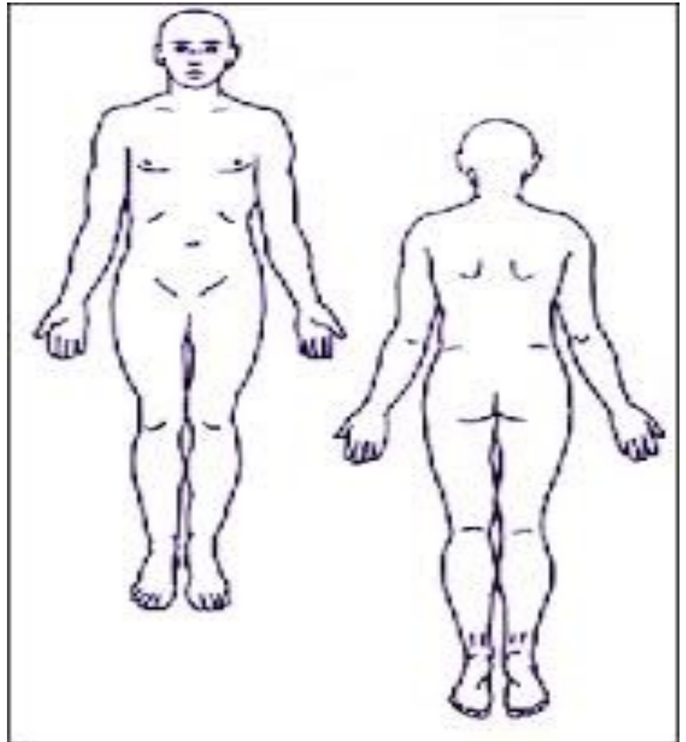
Please circle the areas of compliant:



Please grade you pain / symptoms: 0 1 2 3 4 5 6 7 8 9 10

(0=no pain) (10=severe pain)

Please circle the things that aggravate you condition:

Bending / lifting / twisting / pushing / pulling / driving / sitting / standing / sleeping / walking

Exercising / cleaning / sports / overhead work / computer work / carrying child / driving / working

Please circle the things that relieve your condition:

Ice / heating pad / resting / lying down / medications / sitting / stretching / exercises / massage / chiropractic

Other ____

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Please note that all patients are required to have an examination for determining if chiropractic care is warranted for your condition noted today. With my signature, I agree to allow Denn Chiropractic LLC, to use all chiropractic means to determine my care.

Name: ____ **Date:** _____ / _____ / ______