PINNACLE
CHIROPRACTIC
& SPINAL REHABILITATION

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Auto Accident Section

Patient Name: _____ Date:_____

Date of Accident:_____ Time of Accident:_____ Daylight Dawn Dusk Dark

Injury History:

Were you: **Driver Front Seat Passenger Rear Seat Passenger Other**_____

Your Vehicle (year, make, model):_____

Who owned the car you occupied in this collision_____

Estimated speed at the moment of accident: _____mph **Stopped Slowing Accelerating**

Others in the car?_____

Have they been checked for injuries? **Yes No**

Other vehicle(s) (year, make, model)_____

Number of people in other vehicle(s)_____

What direction were you headed? **North South East West**

Name of street(s)? _____

What direction was the other vehicle headed? **North South East West**

Name of street(s)? _____

Road Conditions: **Dry Damp Wet Snow Icy Other**_____

Seat Head Restraints: **None Integral Type** Adjustable Type: **Up Down Not Sure**

If adjustable, was the position altered by the accident? **Yes No** How?_____

Was the seat position adjustment altered by the accident? **Yes No**

Were You wearing seatbelts? **Yes No Not sure Shoulder & Lap Lap Only**

Did the airbags deploy? **Yes No** If Yes, were you struck? **Yes No** Injuries?_____

Were you struck from? **behind front left side right side**

Body Position? **Normal Forward Lean Other**_____

Head Position: **Forward Looking Left Looking Right Looking up looking down**

Braced for impact: **Yes No** Brakes applied: **Yes No**

Were you looking in the mirror: **Yes No** If yes: **inside rear view outside door mirror L / R**

Brief Description of the Accident:_____
_____
_____

During the accident

Did you strike any parts of the vehicle? **Yes No**
If yes, describe:_____
Did the vehicle strike any objects after initial collision? **Yes No**
If yes, describe:_____
Wearing Hat or glasses? **Yes No** If Yes, were they still on after the crash? **Yes No**
Did you loose consciousness? **Yes No** If yes, for how long?_____
Estimated property damage to your vehicle: $_____
Estimated damage to other vehicle(s): **None Minimal Moderate Major**
Were the police called to the scene? **Yes No**
If yes, was a report made? **Yes No**
If yes, who was found at fault? **You Other Driver**

After the accident

Did you go to the hospital? **Yes No** If no, did you see another doctor? **Yes No**
How did you get there? **Ambulance Car** If by car, were you driven by: **self other**
What treatment did you receive? **exam x-rays neck brace medications other**_____
Have you lost any days of work? **Yes No** If yes, dates:_____
Were you unable to do housework, yard work, etc. due to pain from the accident? **Yes No**
If yes Please describe:_____
Have you been in other auto accidents? **Yes No** If yes dates_____

Auto Insurance Information

Company insuring vehicle you occupied:_____ Accident Claim #_____
Your insurance agents name:_____ Phone #_____
Claims address_____ Phone #_____
Claim adjusters name_____

Company insuring other vehicle :_____ Accident Claim #_____
Claims address_____ Phone #_____
Claim adjusters name_____

Diagram the Accident

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PAIN DIAGRAM

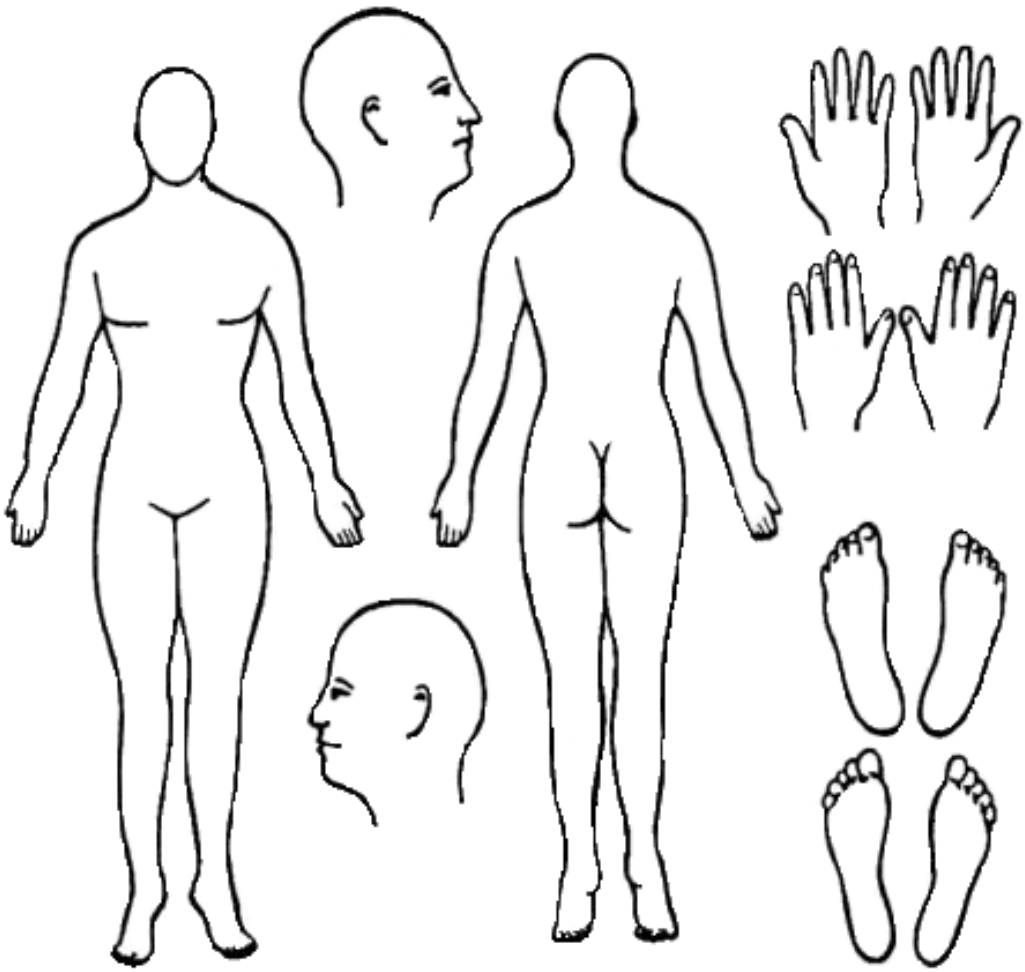
Name:_____ Date:_____

TELL US WHERE YOU HURT

Please read carefully:

Mark the diagram below where you feel your pain. Include all affected areas. Use the appropriate symbol(s) listed below to describe the type of pain. If your pain radiates (travels), draw an arrow from where it starts to where it stops. Please extend the arrows as far as the pain travels

Ache >>>>>	Numbness = = = = = =	Pins Needles 0 0 0 0 0 0 0 0
Burning X X X X	Stabbing / / / / / / / / / / /	Throbbing ~ ~ ~ ~ ~ ~ ~ ~ ~



Severity of Pain

List region of pain and circle the pain level.
(1 = Least, 10 = Greatest)

ex. Neck
1 2 3 (4) 5 6 7 8 9 10

1._____
1 2 3 4 5 6 7 8 9 10

2._____
1 2 3 4 5 6 7 8 9 10

3._____
1 2 3 4 5 6 7 8 9 10

4._____
1 2 3 4 5 6 7 8 9 10

5._____
1 2 3 4 5 6 7 8 9 10

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RED FLAG QUESTIONNAIRE

NAME_____ DATE_____ AGE_____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box
THANK YOU!

YES	NO	?	CA
			Do you have past history of cancer?
			Have you had any unexplained weight loss?
			Does your pain improve with rest?
			Are you over 50 years old?
			Have you failed to improve with a course of conservative care (4-6 weeks)?
			Have you had spinal pain for more than 4 weeks?

YES	NO	?	INF
			Prolonged use of corticosteroids (such as organ transplant Rx)?
			Intravenous drug use?
			Current or recent urinary tract, respiratory tract or other infection?
			Immunosuppressant medication &/or condition?

YES	NO	?	SP FX
			History of significant trauma?
			Minor trauma in person >50 years old?
			Do you have osteoporosis (weak bones)?
			Are you over 70 years old?
			Any prolonged use of corticosteroids

YES	NO	?	Cauda Eq
			Acute onset urinary retention or overflow incontinence (wet underwear)?
			Loss of anal sphincter or fecal incontinence (bowel accidents)?
			Saddle anesthesia (numbness in groin region)?
			Global or progressive muscle weakness in the legs (legs give out)?

Patient Signature:_____

****

Dr's Comments:_____

_____

_____

YOUR HEALTH PROFILE

Name:_____Age:_____Date:_____

Address: _____

Street City State Zip

Home Phone:(_____)_____ Work Phone:(_____)_____ Cell Phone:(_____)_____

Email Address: _____Male:_____ Female:_____

Social Security #:_____Driver's Lic. # _____ Birth Date:_____

Single:_____ Divorced:_____ Widowed: _____ Married:_____ Spouse's Name: _____

Occupation/ Employer's Name: _____

Spouse's Occupation/ Employer: _____

Person to contact in case of emergency :_____ Phone #:(____)_____

Who may we Thank for referring you to our office? _____

Reason For Consulting our office?_____

Why This Form Is Important

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are first, to address the issues that brought you to this office and second, to offer you the opportunity of improved potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some things starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

	Yes	No	Unsure
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious fall as a child?	☐	☐	☐
Did you play sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have surgery?	☐	☐	☐
Did you ever fall/ jump from a height over three feet?(i.e. crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents?	☐	☐	☐

	Yes	No	Unsure
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (emotional or physical)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular chiropractic Care?	☐	☐	☐

Comments:_____

_____

Adult—(18 to Present)

	Yes	No	Unsure
Do/did you smoke?	☐	☐	☐
Do/did you drink alcohol?	☐	☐	☐
Have you been in any accidents?	☐	☐	☐
Have you had any surgery?	☐	☐	☐
(Women) Are you pregnant?	☐	☐	☐

Due Date:_____

	Yes	No	Unsure
Do/ did you play any adult sports?	☐	☐	☐
Do/did you participate in extreme sports?	☐	☐	☐

On a scale of 1-10 describe your stress levels (1=none/10=extreme)

Occupational:_____

Personal:_____

On a Scale of Poor, Good, Excellent describe your:

Diet: _____ Exercise:_____ Sleep:_____ General Health:_____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for Wellness Services, please check here: ☐

Others, please briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it…

☐ Sharp ☐ Stabbing ☐ Burning ☐ Dull/Aching ☐ Constant ☐ Comes and goes

Since the Problem Started, is it…

☐ About the same ☐ Getting Better ☐ Getting worse

What makes it worse:_____

What makes it better:_____

Yes it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

Chiropractor:_____

Medical Doctor:_____

Other:_____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Dizziness	☐ Lights bother eyes	☐ Loss of Balance
☐ Neck Pain	☐ Pins and needles in arms	☐ Weakness in the arms	☐ Ringing/buzzing in the ears
☐ Neck stiffness	☐ Cold Hands	☐ Cold Feet	☐ Fainting
☐ Back Pain	☐ Pins and needles in legs	☐ Weakness in the legs	☐ Numbness in the groin
☐ Nervousness	☐ Depression	☐ Irritability	☐ Tension
☐ Diarrhea	☐ Constipation	☐ Stomach Upset	☐ Heartburn
☐ Fatigue	☐ Sleeping Problems	☐ Problem Urinating	☐ Ulcers
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Fever

List any Medications you are taking:_____

_____

Allergies:_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about:

You:_____

Spouse:_____

Children:_____

How many children do you have?_____ What ages are they?_____

Have you ever:

Bought bottled water?	Yes	No
Belonged to a health club?	Yes	No
Consumed vitamins or supplements?	Yes	No

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____

Signature ***Date***