LIVING WELL CHIROPRACTIC INC., PC

1304 Yelm Ave E., Suite A109 · Yelm, WA 98597 Office 360.458.7533 · Fax 360.458.7699

Patient Name: ____ **Today's Date:** _________________

Date of Accident: _____________________________ **Time of Accident:** ________________ **AM / PM**

Accident Description: ____

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____

Were you the: _____ **Driver** _____**Front Passenger** _____**Rear Passenger** ____ **Pedestrian**

How many people were in the vehicle at the time? _____ **Vehicle Driven by:** ___________________

ACCIDENT DIAGRAM

ACCIDENT SITE

Road/Street Name: _________________________________

City/State: ____

Nearest intersection with road/street: _________________

Driving condition: ____**Dry** ____**Wet** ____**Icy** ____**Other**

POLICE

Did the police come to the accident site? _____**Yes** ____ **No**
Were there any witness? ____**Yes** ____**No**
Was a police report filed? ____**Yes** ____**No**
Was a traffic violation issued? ____**Yes** ____**No** **If yes, to whom?** _________________________

PATIENT'S VEHICLE

Make and model of vehicle you were in? ____

Head restraints: ____ **None** ____**Integral type** ____ **Adjustable type**

Was head restraint: ____ **Up** ____ **Down** **Did the seat or anything else break?** ____**Yes** ____**No**

Were you wearing a seatbelt? ____**Yes** ___ **No** **If yes, what type?** ____**Lap** ____ **Shoulder**

Did airbag deploy? ____**Yes** ____**No** **If yes, were you struck?** ____**Yes** ____**No**

Approximate speed of your vehicle: _____________ **Approximate property damage:** _____________

OTHER VEHICLE(S)
(If Applicable)

Make and model of the other vehicle(s):____

Direction of other vehicle(s): ______________________ **Approximate Speed of vehicle**: _________

IMPACT

Did your car impact another vehicle other than 3rd party? ____ **Yes** ____ **No**

If yes, describe: ____

Did your car impact any type of structure? ____ **Yes** ____**No** **If yes, explain** _________________

____

Did any part of your body strike anything in the vehicle? ____ **Yes** ____ **No**

If yes, explain: ____

Was impact from: ____**Front** ____ **Rear** ____ **Left** ____**Right** ____**Other** _________________

At the time of impact what was your body position? _______________________________________

In what position were your hands? ____

Was your foot on the brake? ___ **Yes** ____**No** ____**N/A** **If yes, which foot?** ____**Right** ____**Left**

Where you wearing anything that fell off due to the impact? ____**Yes** ____**No**

If yes, what?____

Were you holding anything at the time of impact? ____**Yes** ____**No** **What:**____________________

PATIENT CONDITION

Was consciousness lost immediately following the accident? ____**Yes** ____**No**

If yes, for how long? _____________ **Symptoms following the accident were:** _________________

____

____

____

____

TREATMENT RECEIVED

Did you go to the hospital/clinic? ____**Yes** ____**No** **Name of Hospital**_______________________

When did you go?____**Immediately after the accident** ____**Next Day** ____**2 days or more after MVA**

How did you get there? ____**Ambulance** ____ **Private transportation**

Treatment received/Medications: ____

X-rays taken: ____Yes ____No Part of body imaged: ____

Lab work: ____Yes ____No _____Cervical collar ____Ice

SYMPTOMS/INJURIES

Have you been able to work or attend school since this accident? ____Yes ____No

How many work/school days have you missed? ____

Have you have any of the following symptoms since your injury?

____ Shortness of breath ____ Shoulder pain R/L/B ____Feet/toe numbness R/L/B

____ Neck pain ____ Chest pain R/L/B ____Hand/finger numbness R/L/B

____ Neck stiffness ____ Back stiffness ____Arm pain/numbness R/L/B

____ Back pain ____ Memory loss ____Leg pain R/L/B

____ Dizziness ____ Nausea ____Blurred Vision R/L/B

____ Headaches R/L/Front/Back Other: ____

Is the condition getting progressively worse? ____Yes ____No ____Unknown

Type of pain: ____Sharp ____Dull ____Throbbing ____Aching ____Shooting ____Burning

____Tingling ____Cramps ____Stiffness ____Swelling ____Tiredness ____Other:____________

How frequent if your pain?

____ Intermittent – Pain occurs less than 25% of waking hours

____ Occasional – Pain occurs 25% to 50% of waking hours

____ Frequent – Pain occurs 50% to 75% of waking hours

____ Constant – Pain occurs 75% to 100% of waking hours

Does it interfere with your:

____Work

____Sleep

____Daily routine

Activities/movements painful to perform: ___Sitting ___Standing ___Walking ___Bending

___ Lying down ___Other ______________________________

FAMILY HISTORY

Parents: Mother ____alive ____deceased Father ___alive ___deceased

Cause of death____

Diseases in the family ____

SOCIAL HISTORY

Marital status __________Children_________ Use of drugs/alcohol/tobacco ______________

Occupation_________________________ Level of Education: ______________________

Females: Are you taking any oral contraceptives? ____

PAST MEDICAL HISTORY

Prior major illness/injuries/allergies ____

____

Prior operations/hospitalizations ____

____

Prior auto accident/work injuries ____

____

Current medication prescription/over the counter ____

The statements made in these documents are true and accurate to the best of my recollection.

Signature ______________________________________ Date ______________CT Initials ______
(Patient or Legal Guardian)

Additional Notes: ____

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