EUPHORIC HEALING
Chiropractic Health Center

Patient Name _____ Date _____

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: _____

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

If yes, please describe: _____

Make and model of the vehicle you were occupying? _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the : ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle…

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

_____

_____

_____

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After Injury

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: ☐ D.C. ☐ M.D ☐ D.O ☐ D.D.S

Describe any treatment you received: _____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/ shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/	☐ Lower back pain
☐ Blurred vision	☐ Tension	fingers	☐ Back stiffness
☐ Buzzing in ear	☐ Neck pain	☐ Chest pain	☐ Leg pain
☐ Ears ringing	☐ Neck stiff	☐ Shortness of breath	☐ Numb feet/ toes
		☐ Stomach upset	

☐ Other _____

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Patient Name _____ Date _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back……	☐	☐	☐
Lying on side……	☐	☐	☐
Lying on stomach……	☐	☐	☐
Sitting……..	☐	☐	☐
Standing……..……	☐	☐	☐
Stretching……	☐	☐	☐
Lovemaking……..	☐	☐	☐
Walking……	☐	☐	☐
Running……	☐	☐	☐
Sports……..	☐	☐	☐
Working……	☐	☐	☐
Lifting……	☐	☐	☐
Bending……...	☐	☐	☐
Kneeling……...	☐	☐	☐
Pulling……..	☐	☐	☐
Reaching…….	☐	☐	☐

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom? _____

His/ Her phone #:_____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above
☐ Walking	☐ Crawling	head
☐ Lifting	☐ Bending	☐ Typing
		☐ Stooping

☐ Other _____

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What positions can you work in with minimum physical effort and for how long?

_____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____

☐ Adult patient ☐ Parent or Guardian ☐ Spouse