BETTER HEALTH CHIROPRACTIC
6166 W GULF TO LAKE HWY
CRYSTAL RIVER, FL 34429

AUTO ACCIDENT FORM

Patient Name: _____ Date: _____

Date of Accident: _____

Describe the Accident: _____
_____
_____
_____.

MOBILE ACCIDENT INFORMATION

1. Where were you seated in the vehicle? _____
2. Where was your vehicle hit? _____
3. Speed you were going:_____ mph
4. Speed of other vehicle(if applicable): _____ mph
5. Number of passengers in your vehicle: _____
6. Were you wearing a seatbelt? Y or N
7. Were you using headrest? Y or N
8. Did you hit inside the vehicle? Y or N
9. If you answered yes for #8, where: _____
10. Weather conditions at the time of accident: _____

Did patient have immediate pain? Y or N
Was patient rendered unconscious? Y or N
Was patient able to walk unaided Y or N

Did patient go directly to:
A. Home
B. Hospital
C. Other

How did the patient leave accident?
A. own auto
B. ambulance
C. police car

Regions where patient had symptoms?
A. Cervical
B. Cervical & Thoracic
C. Cervical, Thoracic & Lumbar
D. Cervical & Lumbar
E. Thoracic
F. Thoracic & Lumbar
G. Lumbar
H. Other: _____

Immediately after accident did patient:
A. rest
B. was examined
C. other: _____

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Did patient receive treatment? **Y** or **N**
Did patient stay in confinement? **Y** or **N**

The patient spent a:
A. uneventful
B. restless
C. painful night

The next day patient felt:
A. better
B. worse
C. the same
D. aching

Experiencing:
A. relief
B. pain
C. numbness

Has the patient missed work? **Y** or **N** from_____ to _____
Has patient's present complaint interfered with activities? **Y** or **N**
Has patient's present complaint lessened activities? **Y** or **N**
Has patient's present complaint eliminated activities? **Y** or **N**

Examples: working- keeping house - sitting - bending - bathe or dress yourself- attend church climbing – sleeping- driving- riding- sex- stooping- lifting – pushing- grip - recreation - social pulling- walking- kneeling- care for baby

Has patient seen other Doctor's for this condition? **Y** or **N**
Name of Doctor: _____
Date seen: _____
Results: _____

More than one? **Y** or **N**
Name of Doctor: _____
Date seen: _____
Results: _____

Has patient's condition:
A. Improved since accident
B. Not improved since the accident
C. Worsened since the accident
D. Remained the same since accident

OCCUPATIONAL HISTORY

Are you employed? **Y** or **N**
If yes: Patient's occupation_____
Does your job require: A. standing B. sitting C. walking D. all of the above
Does your job require lifting? **Y** or **N** # of hours _____ how many lbs._____
Is help available for lifting **Y** or **N**
Does your job require full movement of: A. cervical B. dorso- lumbar C. both
Does your job require full movement of: A. upper extremities B. lower extremities C. both
Does the patient have a past history of injury? **Y** or **N**

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Prior injury:

A. Auto

B. Work related

C. Assault

D. Fall

E. Accident

Area of injury:

A. Cervical

B. Cervical & Thoracic

C. Cervical & Lumbar

D. Cervical, Thoracic & Lumbar

E. Thoracic

F. Thoracic & Lumbar

G. Lumbar

Year: _____

Was a full recovery made? **Y** or **N**

If patient has not recovered from this accident, what statement would you like to make:_____
_____.

Shade the area of present pain.