

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

AUTO ACCIDENT FORM

Patient Name: _____

Date: _____

Date of Accident: _____

Does the patient have a past history of injury? **Y** or **N**

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

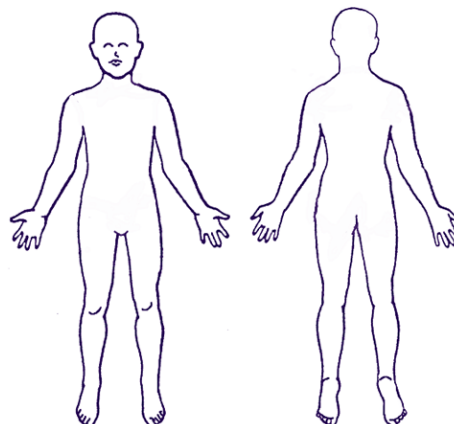
Year: _____

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

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

_____.

Shade in areas of pain:



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Description of recent
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

Regions where patient had symptoms?

- A. Cervical
- B. Cervical & Thoracic
- C. Cervical, Thoracic & Lumbar
- D. Cervical & Lumbar
- E. Thoracic
- F. Thoracic & Lumbar
- G. Lumbar

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

Immediately after accident did patient:

- A. rest
- B. was examined
- C. other

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

If the patient did not rest or was not examined, then what?

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

In which area did the patient experience the above?

- | | | |
|---------------------------------|----------------------|-----------|
| A. Cervical | D. Cervical & Lumbar | G. Lumbar |
| B. Cervical & Thoracic | E. Thoracic | |
| C. Cervical, Thoracic, & Lumbar | F. Thoracic & Lumbar | |

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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

Do you want an occupational history on patient? **Y** or **N** if yes: Patient's
occupation _____ # of months _____ # of years _____ at this occupation.
Does job require: A. standing B. sitting C. walking D. all of the above
Does job require lifting? **Y** or **N** # of hours _____ how many lbs. _____
Is help available for lifting **Y** or **N**

Does job require full movement of: A. cervical B. dorso- lumbar C. both
Does job require full movement of: A. upper extremities B. lower extremities C. both

MOBILE ACCIDENT INFORMATION

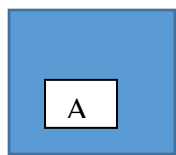
1. Where were you seated in the car? _____
2. Where was your car hit? _____
3. Speed you were going: _____ mph
4. Speed of other car: _____ mph
5. Number of passengers in your car: _____

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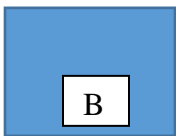
- 6. Were you wearing a seatbelt? Y or N
- 7. Were you using headrest? Y or N
- 8. Did you hit inside the car? Y or N
- 9. If you answered yes for #8,
explain_____

10. Weather conditions at the time of accident:

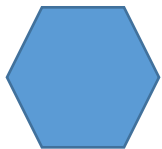
11. Diagram of auto accident :



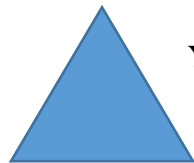
Your car



Other car



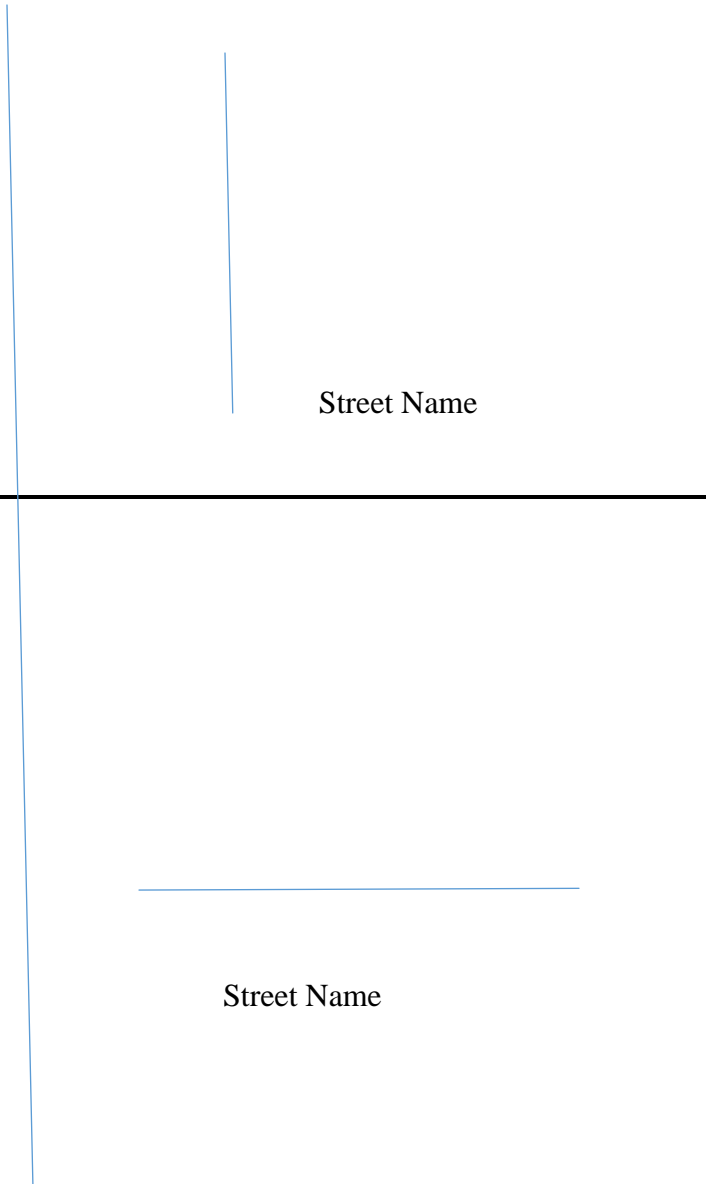
Stop sign



Yield sign



Direction of travel



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