ORLANDO SPORTS CHIROPRACTIC

7513 West Sand Lake Rd., Orlando, FL 32819 ♦ 407-345-8686

AUTOMOBILE ACCIDENT HISTORY FORM

Full Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Occupation _____

Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Age _____ Birthday _____/_____/_____

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other _____ SS# _____

Referred By: Attorney _____ Insurance _____

Doctor _____ Other _____

HISTORY OF ACCIDENT (check all that apply)

1. Date of Accident _____ Time of Accident _____ Date of Exam _____
2. Description of Accident _____

_____

_____

_____

3. Location of Accident Street _____ City _____ State _____
4. ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other _____
5. ☐ Traveling ☐ Stopped facing ☐ N ☐ S ☐ E ☐ W ☐ Unknown Direction
6. **YOUR** Vehicle Type: ☐ Compact ☐ Midsize ☐ Truck ☐ Sport Utility ☐ Van ☐ Semi-truck
7. **OTHER** Vehicle Type(s): ☐ Compact ☐ Midsize ☐ Truck ☐ Sport Utility ☐ Van ☐ Semi-truck
8. Who was issued the citation? ☐ Nobody, we exchanged insurance info ☐ I was / My party ☐ Other party
9. ☐ Stopped and rear-ended ☐ Moving and rear-ended ☐ Slowing down to make stop / turn and rear-ended

   ☐ Head-on collision – other vehicle traveling in opposite direction ☐ Side swiped RIGHT / LEFT ☐ Rolled over

   ☐ Another vehicle ran stop sign / red light ☐ Lost control of vehicle ☐ Spun around ☐ T-boned RIGHT / LEFT
10. If rear-ended, did the force of the impact cause your vehicle to collide with another vehicle? ☐ Yes ☐ No
11. Road conditions at the time of the accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other _____
12. Approximate speed of **YOUR** vehicle: _____mph
13. Approximate speed of **OTHER** vehicle: _____mph
14. Were you wearing a seat belt? ☐ Yes ☐ No Were you aware of the impending collision? ☐ Yes ☐ No
15. How far is the top of the headrest or seatback from the top of your head? (measurement in inches)

    ☐ 0" ☐ 1" ☐ 2" ☐ 3" ☐ 4" ☐ 5" ☐ 6" ☐ Other _____ ☐ Above ☐ Below
16. Did you strike any objects in the car? ☐ Yes ☐ No
17. If yes, then what? ☐ Steering column ☐ Rearview mirror ☐ Seat broke ☐ Dashboard

    ☐ Door frame ☐ Headrest ☐ Jarred or thrown about ☐ Windshield

    ☐ Cannot remember details (dazed) ☐ Other _____
18. What portion of your body did you strike? ☐ Head ☐ Chest ☐ Face ☐ Arms ☐ Hands ☐ Legs ☐ Knees

    ☐ Shoulder ☐ Hip ☐ Other _____

19. As a result of the accident were you? ☐ not injured ☐ cut/bleeding ☐ bruised ☐ dizzy ☐ nauseas
☐ blurred vision ☐ unconscious ☐ ringing/buzz in ears ☐ partially paralyzed ☐ other _____

20. If cut, bruised, and/or partially paralyzed please explain where _____

21. If you experienced immediate pain, please indicate where:

☐	Headache	☐ Left	☐ Right	☐	Neck pain	☐ Left	☐ Right
☐	Upper-back pain	☐ Left	☐ Right	☐	Mid-back pain	☐ Left	☐ Right
☐	Chest pain	☐ Left	☐ Right	☐	Low-back pain	☐ Left	☐ Right
☐	Arm	☐ Left	☐ Right	☐	Elbow	☐ Left	☐ Right
☐	Knee	☐ Left	☐ Right	☐	Leg	☐ Left	☐ Right
☐	Other _____						

22. After the accident, did you? ☐ go home ☐ go to work ☐ go about your business ☐ go to the hospital

HOSPITALIZATION

23. If taken to the hospital, how did you get there? ☐ Ambulance ☐ Driven by friend / relative ☐ Drove yourself ☐ Went later

24. If you went later, then when? _____ Name of hospital _____

25. Were you seen in the emergency room? ☐ Yes ☐ No

26. Were you admitted to the hospital? ☐ Yes ☐ No

27. If admitted, how long did you stay? _____

28. Name of admitting or hospital physician? _____

29. What was done in the emergency room or hospital? ☐ Examination ☐ Stitches ☐ X-rays ☐ Surgery
☐ Physical Therapy ☐ Casting ☐ Cervical collar ☐ Prescription(s) _____
☐ Other _____

30. After being released, what did you do? ☐ Return home to bed ☐ Return to work ☐ Return to the emergency room
☐ Other _____

31. When did you first consult a physician? ☐ Same day ☐ Following day ☐ Within a few days
☐ Did not consult one ☐ Other _____

(If patient consulted this office, skip to PAST HISTORY)

32. Who did you consult? Dr. _____ ☐ Family Physician ☐ Chiropractor ☐ Orthopedist
☐ Osteopath ☐ Neurologist ☐ Other _____

33. What did the doctor do? ☐ Chiropractic manipulation ☐ Examination ☐ X-rays ☐ Injections ☐ Traction
☐ Physiotherapy ☐ Prescription(s) _____ ☐ Other _____

34. How long were you under this doctor's care? _____

35. Are you still under this doctor's care? ☐ Yes ☐ No

36. Frequency or number of visits now? _____

37. Did the doctor refer you to or have you been to any other physician? ☐ Yes ☐ No
If yes, explain: _____

38. Were you sent for an independent medical examination? ☐ Yes ☐ No
If yes, to whom? _____

39. Other pertinent information _____

_____

_____

PAST HISTORY

40. Have you ever been in any previous accident of any kind? ☐ Yes ☐ No

If yes, please give dates and details _____

_____

_____

41. Were you rendered permanently impaired? ☐ Yes what % _____ ☐ No

42. Has any other physician prior to this accident ever treated you for neck or back problems? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

43. Have you had any previous surgeries or any conditions that I should know about? ☐ Yes ☐ No

If yes, please explain _____

_____

44. Were you symptom free and in good health before this accident? ☐ Yes ☐ No

If no, please explain _____

_____

_____

_____

PRESENT COMPLAINTS

45. Please list your current problem areas (prioritize with worst being #1)

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

46. Have you lost any time from work since the accident? ☐ Yes ☐ No

47. If yes, how many days? _____ Are you still off work? ☐ Yes ☐ No

48. Date returned _____ Job description _____

49. In what way have your injuries affected your ability to work? _____

_____

_____

50. Have your injuries affected your hobbies and/or recreational activities? ☐ Yes ☐ No

51. If yes, please explain. _____

_____

_____

49. If you have an attorney representing you, please give name, address, and telephone number:

Name _____ Firm _____

Address _____ City _____

State _____ Zip _____ Phone _____