



Motor Vehicle Accident Form
(Please Print)

Name _____ Date _____

Dr./Mr./Mrs./Ms./Miss (circle one) Marital status (circle one) M S W D

Last Name _____ First Name _____ Middle Initial _____ Nick Name _____

Address _____ City _____ State _____ Zip Code _____

Home phone: _____ Mobile Phone: _____

Email address: _____

Social Security No. _____ Date of Birth _____ Sex [] M [] F

Occupation (specific job title) _____

Person to contact in case of emergency _____ Phone: _____

EMPLOYER INFORMATION

Company Name _____ Supervisor Name _____ Work Phone# _____

Address _____ City _____ State _____ Zip Code _____

INSURANCE INFORMATION

If you have any insurance information please give it to the staff person assisting you.

RESPONSIBLE PARTY

Name of person responsible for payment of this account _____

Relationship to patient _____ Phone: _____

Address _____ City _____ State _____ Zip Code _____

CRASH/INJURY HISTORY

1. Date of Accident: _____ Time of Day: _____ Road Condition: [] Dry [] Wet

2. Were you: [] Driver [] Passenger [] Front Seat [] Back Seat

3. Number of people in your vehicle? _____

4. Were you wearing a seat belt? [] Y [] N If no, please skip to question #6

5. If yes, were you wearing a lap belt? [] Y [] N Lap belt & shoulder harness? [] Y [] N

6. What direction were you headed? [] North [] South [] East [] West

(If you unsure, please leave direction questions blank)

On (name of street and city): _____

7. What direction was the other vehicle headed? [] North [] South [] East [] West

On (name of street and city): _____

8. Were you struck from: [] Behind [] Front [] Left Side [] Right Side

Other combination, please describe: _____



9. What was the position of your head during the crash?

Straight Ahead Turned Right Turned Left Other

10. Did any part of your body strike/hit anything inside your vehicle (steering wheel, dashboard, etc)?

Y N If yes, please explain _____

11. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)? Y N

If yes, please describe: _____

12. If your vehicle was equipped with air bags, did they activate? Y N

13. Make/model of your vehicle: _____

14. Make/model of the other vehicle: _____

15. Were the police notified? Y N **Please provide this office with a copy of the police report.**

16. In your own words, please describe the accident: _____

17. Did you have any physical complaints BEFORE the accident? Y N

If yes, please describe in detail: _____

18. Please describe how you felt:

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

19. Did you lose consciousness during the crash? Y N If yes, for how long? _____

20. Where were you taken after the accident? _____

21. Have you been treated by another doctor since this accident? Y N

If yes, please list the doctor's name and address: _____

What type of treatment did you receive? _____

22. Did this accident occur while you were performing your regular job duties? Y N

23. How do you feel now? What is your **number-one** problem or the **one area** of greatest pain?



24. Please rate the level of this pain on the following scale:

(0 is no pain and 10 is severe pain. If your pain varies from day to day, please circle two numbers to indicate that range.)

0 1 2 3 4 5 6 7 8 9 10

25. Since this injury occurred, is your pain: [] Improving [] Getting Worse [] Staying the Same

26. How often do you experience the pain?

___ 1-2 hours per day ___ About half of the day
___ Most of the day ___ The pain never goes away

27. How does the pain affect your daily activities?

___ It does not affect my daily activities ___ I have had to change how I do things
___ I have had to stop doing some daily activities ___ I am unable to perform daily activities

28. What increases your pain? _____

29. What decreases your pain? _____

30. Have you ever experienced this problem before? [] Y [] N When? _____

31. Do you have a previous illness/disease which affects your present condition? [] Y [] N

If yes, please describe: _____

32. List any other complaints currently bothering you and rate your pain level for each.

a. _____ 0 1 2 3 4 5 6 7 8 9 10

b. _____ 0 1 2 3 4 5 6 7 8 9 10

c. _____ 0 1 2 3 4 5 6 7 8 9 10

d. _____ 0 1 2 3 4 5 6 7 8 9 10

33. Have you lost time from work as a result of this accident? [] Y [] N

a. Type of employment: _____

b. Last day worked: _____

34. Have you ever been involved in an accident before? [] Y [] N

a. If yes, when? _____

b. Describe the accident(s): _____

c. Were you injured? [] Y [] N Explain: _____

35. List all surgeries you have had (including the date): _____

36. List all medications you are currently taking (prescribed and over the counter): _____



If you have experienced any of the following conditions in the past, mark a “**P**” on the line provided.
If you are currently experiencing any of the following conditions, mark a “**C**” on the line provided.
(Please check all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> heart attack | <input type="checkbox"/> stroke | <input type="checkbox"/> arthritis | <input type="checkbox"/> gall bladder trouble |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> glaucoma | <input type="checkbox"/> fainting spells | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> difficulty with urination | <input type="checkbox"/> bloody stools | <input type="checkbox"/> difficulty with bowel movements | |
| <input type="checkbox"/> prostate trouble | <input type="checkbox"/> anemia | <input type="checkbox"/> cancer | <input type="checkbox"/> asthma |
| <input type="checkbox"/> menstrual cramping | <input type="checkbox"/> AIDS | <input type="checkbox"/> ulcers | <input type="checkbox"/> diverticulitis |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> loss of memory | <input type="checkbox"/> chest pain | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> general fatigue | <input type="checkbox"/> sudden weight loss |
| <input type="checkbox"/> nausea | <input type="checkbox"/> muscle cramping | <input type="checkbox"/> soreness in joints | <input type="checkbox"/> loss of hearing |
| <input type="checkbox"/> ears ringing | <input type="checkbox"/> headache | <input type="checkbox"/> migraine | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> gout | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> syphilis | |
| <input type="checkbox"/> sprained ankle [] R [] L | <input type="checkbox"/> broken bones (specify): _____ | | |
| <input type="checkbox"/> knee/hip replacement | | | |

General Activities (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> sleep on waterbed | <input type="checkbox"/> read in bed | <input type="checkbox"/> fall asleep in recliner/on couch |
| <input type="checkbox"/> sleep on stomach | <input type="checkbox"/> needlepoint/knitting | <input type="checkbox"/> use 2+ pillows to sleep with |
| <input type="checkbox"/> sewing | <input type="checkbox"/> lift weights/wt. mach. | <input type="checkbox"/> play video games (___ hrs per day) |
| <input type="checkbox"/> exercise _____x/wk | <input type="checkbox"/> jog _____x/wk | <input type="checkbox"/> computer use (___ hrs per day) |
| <input type="checkbox"/> swim | <input type="checkbox"/> use healthrider | <input type="checkbox"/> watch television (___ hrs per day) |

24. Please add anything else you would like the doctor to know: _____

AUTHORIZATION

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient’s Signature _____ Date _____
(signature of parent if the patient is a minor)

Doctor’s Comments: _____

