Patient Name:______________________________ Today's Date______________________________

Date of Injury:____________________ Marital status: ☐M ☐S ☐W ☐D

Smoke: ☐None ☐Pack per day ____Years____ Alcohol ☐Never ☐Social ☐Light ☐Mod ☐Heavy

Employment:

At time of crash: Where did you work?______________________________ ☐Unemployed

Currently: Where do you work?______________________________ ☐Unemployed is it due to crash?☐Y☐N

Type of work: ☐Office/clerical ☐Light labor ☐Moderate Labor ☐Heavy Labor

Past Medical History:

Surgeries (dates and residuals):______________________________

____

____

Fractures (dates and residuals):______________________________

____

____

Serious Illness (dates and residuals):______________________________

____

____

Workers' comp injuries (date, Tx, awards, residuals):______________________________

____

____

Personal Injuries (date, Tx, awards, residuals):______________________________

____

____

Sports or other injuries to head, neck or back:______________________________

____

____

Any prior history of current complaints:______________________________

____

____

Prior treatment by DC for these:______________________________

____

____

Current Medical History:

Current Health Problems: ☐None______________________________

____

____

Current Medications taken: ☐None______________________________

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____

Injury History

General:

Was the crash on the job? ☐Yes ☐No

You were: ☐Driver ☐Front seat passenger ☐Rear seat passenger ☐Motorcycle operator ☐Motorcycle Passenger ☐Other______________________________

Patient Name:______________________________ Date:______________________

Vehicle Driven By:__________________________________

Your Vehicle (year,make,model):____

Your estimated speed at moment of crash:_______ ☐Stopped ☐Slowing ☐Accelerating

Other Vehicle (year,make,model):_________________________ Speed:____________________

Time of Day: ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road Conditions: ☐Dry ☐Damp ☐Wet ☐Snow ☐Ice ☐Other____________

Head Restraints: ☐None ☐Built in ☐Adjustable type ☐Up ☐Down ☐Middle ☐Don't know

If adjustable was the position altered by the crash? ☐Yes ☐No

Was the seat back adjustment altered by the crash? ☐Yes ☐No

Was the seat broken? ☐Yes ☐No

Lap Belt: ☐Wearing ☐Not wearing ☐Don't know

Shoulder Belt: ☐Wearing ☐Not wearing ☐Don't know

Did Airbag deploy? ☐Yes ☐No

If yes, were you struck? ☐Yes ☐No

Body Position ☐Good ☐Forward Lean ☐Other______________________________________

Head Position ☐Forward ☐Left____° ☐Right____° ☐Up______° ☐Down______°

Hands: ☐One on wheel ☐Two on wheel ☐N/A

Brakes applied? ☐Yes ☐No

Crash Description:____

____

____

____

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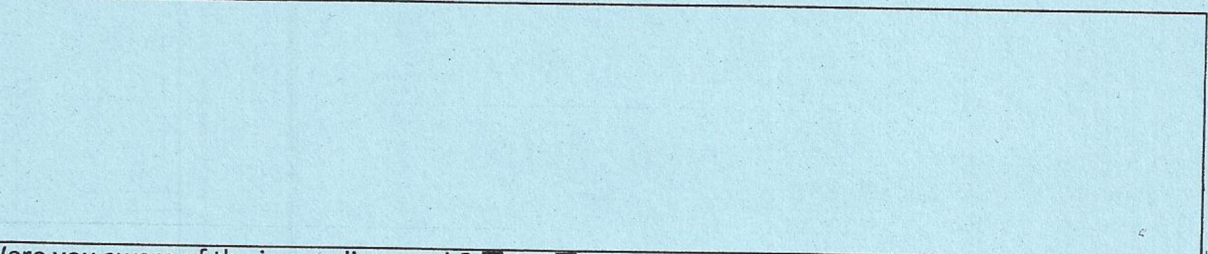
____

Crash Diagram:



Were you aware of the impending crash? ☐Yes ☐No

During the crash:

Did you strike any parts of the vehicle? ☐Yes ☐No If yes, Describe:_______________________

____

Did vehicle strike any objects after the crash? ☐Yes ☐No If yes Describe ________________

____

Were you wearing glasses or a hat? ☐Yes ☐No If yes, were they still on after the crash? ☐Yes ☐No

Patient Name:____ Date:____________________

Did you lose consciousness? ☐Yes ☐No If yes, How long?____________________________________

Estimated property damage to your vehicle? $______________________

Estimated damage to other vehicle(s): None ☐ Minimal ☐ Moderate ☐ Major

Were the police on-scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No

After the crash:

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck Pain

☐ Paresthesia(s)/numbness

If Yes, where?____

☐ Extremity pain If yes, where?____

☐ Back Pain

When did symptoms first appear? ☐ Immediately describe which symptom_____________________

____

____

How many hours afterward?__________

Where did you go after the crash? ☐ Home ☐ Work ☐ Hospital ☐ Other__________________

Mode of transportation__________________________ Pvt. Doctor_________________________________

Emergency Department

Radiographs: ☐ Yes ☐ No Which body parts were imaged?____

Results:____

Lab work? ☐ Yes ☐ No

☐ Cervical collar ☐ Ice

Medications:____

____

Other:____

Follow up instructions: ☐None ☐Other____

____