<table>
<thead>
<tr>
<th><strong>AUTOMOBILE ACCIDENT HISTORY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name</strong></td>
</tr>
<tr>
<td><strong>Was the accident on the job?</strong></td>
</tr>
<tr>
<td><strong>Where were you seated in the vehicle?</strong></td>
</tr>
<tr>
<td><strong>Name of person driving the vehicle</strong></td>
</tr>
<tr>
<td><strong>Your Vehicle</strong> (year, make, model)</td>
</tr>
<tr>
<td><strong>Your estimated speed at the moment of the accident</strong></td>
</tr>
<tr>
<td><strong>If stopped, was your foot on the brake?</strong></td>
</tr>
<tr>
<td><strong>Other Vehicle</strong> (year, make, model)</td>
</tr>
<tr>
<td><strong>Estimated speed of the other vehicle at moment of impact</strong></td>
</tr>
<tr>
<td><strong>Road conditions at the time of the accident:</strong></td>
</tr>
<tr>
<td><strong>Time of day:</strong></td>
</tr>
<tr>
<td><strong>Head restraints, Seat backs:</strong></td>
</tr>
<tr>
<td>How far is the top of the headrest or seatback from the back of your head?</td>
</tr>
<tr>
<td>If adjustable, was the position of the headrest altered by the accident?</td>
</tr>
<tr>
<td>Was the seat back adjustment altered by the accident?</td>
</tr>
<tr>
<td>Was the seat broken</td>
</tr>
<tr>
<td><strong>Seat belts and Air bags:</strong></td>
</tr>
<tr>
<td>Were you wearing a seatbelt?</td>
</tr>
<tr>
<td>What type?</td>
</tr>
<tr>
<td>Did your air bag deploy?</td>
</tr>
<tr>
<td>If yes, were you struck?</td>
</tr>
<tr>
<td><strong>Head and Body position:</strong></td>
</tr>
<tr>
<td>Which way was your body pointed at the point of impact?</td>
</tr>
<tr>
<td>Which way was your head pointed at the point of impact?</td>
</tr>
</tbody>
</table>

**Patient signature** | **Date**
ACCIDENT DIAGRAM

In the space below, please describe, to the best of your knowledge, what happened during this accident

DURING THE CRASH:

- Position of hands: ○ One on wheel ○ Two on wheel ○ N/A
- Did you strike any parts of the vehicle? ○ Yes ○ No
- If yes, please describe
- Did vehicle strike any objects after the crash? ○ Yes ○ No
- If yes, please describe
- Were you aware or surprised of the approaching collision? ○ Aware ○ Surprised
- Were you wearing a hat or glasses? ○ Yes ○ No
- If yes, were they still on after the crash ○ Yes ○ No
- Did you lose consciousness (black out) upon impact? ○ Yes How long? _______ ○ No
- Did you experience a flash of light or explosion in your head? ○ Yes ○ No

AFTER THE CRASH

- Did you become: ○ Confused ○ Disoriented ○ Light headed ○ Dizzy
  ○ Nauseated ○ Blurred vision ○ Ring/Buzz in ears
- If you still have any of those symptoms, which ones: ___________________________

Are you currently suffering from any of the following:

○ Restlessness ○ Irritable ○ Difficulty concentrating ○ Difficulty with memory
○ Sleeplessness ○ Forgetful ○ Reduced tolerance to heat ○ Reduced tolerance to alcohol

Did the police come to the accident scene? ○ Yes ○ No
Is there a report? ○ Yes ○ No

_________________________________________  ____________________________
Patient signature                              Date
ORIGINAL COMPLAINTS- If the accident is more than one month old
If accident was within the last month, skip this section and go to the next page.

1) __________________________________________
   Date when symptom first appeared ________________
   How often did you experience the symptoms?
   ○ Constant 100%    ○ Frequent 75%
   ○ Intermittent 50%  ○ Occasional 25%  ○ Rare 10%
   What made symptom increase? _______________________
   What gave relief of symptom? _______________________
   Type of pain:
   ○ Sharp    ○ Dull    ○ Aching    ○ Burn
   ○ Throb    ○ Numb    ○ Other ____________
   Where did the pain radiate to? ______________________
   Rate the symptoms from 1 to 10 (10 = worst) ____________

2) __________________________________________
   Date when symptom first appeared ________________
   How often did you experience the symptoms?
   ○ Constant 100%    ○ Frequent 75%
   ○ Intermittent 50%  ○ Occasional 25%  ○ Rare 10%
   What made symptom increase? _______________________
   What gave relief of symptom? _______________________
   Type of pain:
   ○ Sharp    ○ Dull    ○ Aching    ○ Burn
   ○ Throb    ○ Numb    ○ Other ____________
   Where did the pain radiate to? ______________________
   Rate the symptoms from 1 to 10 (10 = worst) ____________

3) __________________________________________
   Date when symptom first appeared ________________
   How often did you experience the symptoms?
   ○ Constant 100%    ○ Frequent 75%
   ○ Intermittent 50%  ○ Occasional 25%  ○ Rare 10%
   What made symptom increase? _______________________
   What gave relief of symptom? _______________________
   Type of pain:
   ○ Sharp    ○ Dull    ○ Aching    ○ Burn
   ○ Throb    ○ Numb    ○ Other ____________
   Where did the pain radiate to? ______________________
   Rate the symptoms from 1 to 10 (10 = worst) ____________

4) __________________________________________
   Date when symptom first appeared ________________
   How often did you experience the symptoms?
   ○ Constant 100%    ○ Frequent 75%
   ○ Intermittent 50%  ○ Occasional 25%  ○ Rare 10%
   What made symptom increase? _______________________
   What gave relief of symptom? _______________________
   Type of pain:
   ○ Sharp    ○ Dull    ○ Aching    ○ Burn
   ○ Throb    ○ Numb    ○ Other ____________
   Where did the pain radiate to? ______________________
   Rate the symptoms from 1 to 10 (10 = worst) ____________
CURRENT COMPLAINTS -

Please list, in detail, all current symptoms / complaints in order of severity

1) ________________________________

Date when symptom first appeared _________________

How often do you experience the symptoms?

☐ Constant 76-100% ☐ Frequent 51-75%
☐ Intermittent 26-50% ☐ Occasional 11-25% ☐ Rare 10%

Describe any recently related accident or fall _________________

__________________________________________________________

What makes symptom increase? ____________________________

What gives relief of symptom? _____________________________

Type of pain:

☐ Sharp ☐ Dull ☐ Aching ☐ Burn
☐ Throb ☐ Numb ☐ Other _________________

Where does the pain radiate to? ____________________________

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 _______________ 5 _______________ 10

2) ________________________________

Date when symptom first appeared _________________

How often do you experience the symptoms?

☐ Constant 76-100% ☐ Frequent 51-75%
☐ Intermittent 26-50% ☐ Occasional 11-25% ☐ Rare 10%

Describe any recently related accident or fall _________________

__________________________________________________________

What makes symptom increase? ____________________________

What gives relief of symptom? _____________________________

Type of pain:

☐ Sharp ☐ Dull ☐ Aching ☐ Burn
☐ Throb ☐ Numb ☐ Other _________________

Where does the pain radiate to? ____________________________

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 _______________ 5 _______________ 10

Please mark your areas of pain on the figures below

Patient Name

Patient signature _______________ Date ________

ACCIDENT HISTORY PAGE 4
CURRENT COMPLAINTS Continued

3)  

Date when symptom first appeared ______________

How often do you experience the symptoms?

- Constant 76-100%
- Frequent 51-75%
- Intermittent 26-50%
- Occasional 11-25%
- Rare 10%

Describe any recently related accident or fall ______________

What makes symptom increase? _______________________

What gives relief of symptom? _______________________

Type of pain:  

- Sharp
- Dull
- Aching
- Burn
- Throb
- Numb
- Other _______________________

Where does the pain radiate to? _______________________

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 ______________ 5 ______________ 10

---

4)  

Date when symptom first appeared ______________

How often do you experience the symptoms?

- Constant 76-100%
- Frequent 51-75%
- Intermittent 26-50%
- Occasional 11-25%
- Rare 10%

Describe any recently related accident or fall ______________

What makes symptom increase? _______________________

What gives relief of symptom? _______________________

Type of pain:  

- Sharp
- Dull
- Aching
- Burn
- Throb
- Numb
- Other _______________________

Where does the pain radiate to? _______________________

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 ______________ 5 ______________ 10

---

Patient Signature ______________________   Date ______________
### PLEASE LIST ALL PREVIOUS TREATMENTS FOR CONDITIONS RELATED TO THIS ACCIDENT

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Address</th>
<th>Phone #</th>
<th>Specialty</th>
<th>Dates of care</th>
<th>Tests/Treatments</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tbody>
</table>

________________________

Patient Signature

________________________

Date
PAST HEALTH HISTORY

PLEASE LIST ALL SURGERIES YOU HAVE HAD

<table>
<thead>
<tr>
<th>Type</th>
<th>When</th>
<th>Doctor</th>
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<tbody>
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</table>

PLEASE LIST ALL PREVIOUS FRACTURES AND DISLOCATIONS

<table>
<thead>
<tr>
<th>What</th>
<th>When</th>
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<tr>
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<tr>
<td>Remarks</td>
<td></td>
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</tbody>
</table>

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

<table>
<thead>
<tr>
<th>What</th>
<th>Frequency</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
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</table>

PLEASE LIST ANY PRIOR HISTORY OF CURRENT COMPLAINTS

<table>
<thead>
<tr>
<th>Date</th>
<th>Complaint</th>
<th>Treatment</th>
<th>Result</th>
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<tbody>
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</table>

PLEASE LIST ALL PRIOR ACCIDENTS, ASSOCIATED COMPLAINT AND TREATMENTS

<table>
<thead>
<tr>
<th>Date</th>
<th>Complaint</th>
<th>Treatment</th>
<th>Result</th>
</tr>
</thead>
<tbody>
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</table>

OCCUPATIONAL INFORMATION

Job Involves:

- Sitting
- Standing
- How long
- Desk
- Counter
- Other
- Lifting
- How much weight
- Bending
- Stooping
- Twisting
- Turning
- Type of shoes
- High heels
- Boots
- Arch supports
- Other
- How long do you speak on the telephone each day
- Traditional telephone receiver
- Headset
- Physical activity at work
- Sedentary
- Light manual labor
- Manual labor
- Heavy manual labor
- Do any of your work activities aggravate your present main complaints? Please describe

--------------------------------------------------

Patient Signature  ____________________________ Date

ACCIDENT HISTORY PAGE 7
HEALTH HABITS: How much per day or week?

Tea, coffee  ____________________  Liquor  ____________________  Tobacco  ____________________  Sugar, candy, ice cream  ____________________

Exercise:
1) Type  _______________  Frequency  _______________  2) Type  _______________  Frequency  _______________
3) Type  _______________  Frequency  _______________  4) Type  _______________  Frequency  _______________

Sleep:
Hours per night  _______________  Type of mattress  _______________  Naps  _______________
Do you sleep on your  ☐ Back  ☐ Side  ☐ Stomach
Please describe your sleep  ___________________________________________

Special diets  _______________________________________________________

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD

☐ HIV Positive  ☐ Goiter  ☐ Tuberculosis  ☐ Diabetes  ☐ Malaria  ☐ Pneumonia
☐ Anemia  ☐ Gout  ☐ Typhoid Fever  ☐ Diptheria  ☐ Measles  ☐ Polio
☐ Appendicitis  ☐ Heart Disease  ☐ Ulcers  ☐ Eczema  ☐ Miscarriage  ☐ Rheumatic Fever
☐ Arteriosclerosis  ☐ Herpes  ☐ Venerial Infection  ☐ Emphysema  ☐ Mumps  ☐ Scarlet Fever
☐ Arthritis  ☐ Influenza  ☐ Whooping Cough  ☐ Epilepsy  ☐ Pleurisy  ☐ Stroke
☐ Cancer  ☐ Lumbago  ☐ Cold Sores  ☐ Hypersensitivity  ☐ Other  ____________________
☐ Tuberculosis  ☐ Small Pox  ☐ Allergies  ☐ Asthma  ☐ Chicken Pox

DISABILITY

Do you have a permanent disability rating?  _______________  Location  ____________________  Date received  _______________
Rating Percentage  ____________________________________________

X-RAY CONFIRMATION- FEMALES

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

Signed  ____________________  Date  ____________________

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge

Patient Signature  ____________________  Date  ____________________

DOCTORS NOTES:

ACTIONS TAKEN ON THIS VISIT

☐ Examination/TX  ____________________________________________
☐ X-rays  ____________________________________________
☐ Disability  ____________________________________________
☐ Work restriction  _________________________________________
☐ Supplies  _______________________________________________
☐ Tests/Referrals  __________________________________________

ACCIDENT HISTORY PAGE  8