HISTORY OF CAR ACCIDENT

Please fill out these forms: If you have questions LEAVE BLANK

Your Name _____

Today's Date _____ Date of Accident _____

Age _____ Date of birth _____ Occupation _____

Are you currently under the care of any doctor for anything and if so list doctor and reason?

___ No ___ Yes If yes, fill in the following:

Doctor _____

Reason _____

Doctor _____

Reason _____

Have you ever had any surgery? ___ No ___ Yes. If yes:

What kind of surgery? _____

When was the surgery? _____

Have you ever been hospitalized? ___ No ___ Yes. If yes:

Why were you hospitalized? _____

When were you hospitalized? _____

If you and/or any relative has had any of the following please write the letter that is appropriate:

Y = yourself, F = father, M = mother, GP = grandparent

diabetes _____ high blood pressure _____ cancer _____

arthritis _____ heart attack _____ stroke _____

epilepsy _____ Rheumatic Fever _____ concussion _____

Check any that apply

___ I have constant headaches.

___ I get tired easily.

___ I feel sick at my stomach a lot.

___ I am a male.

___ My memory is getting worse.

___ It is easier to get drunk.

___ I am a female.

___ I have lost my sex drive.

___ I am dizzy a lot of the time.

___ It is hard for me to fall asleep.

___ I might be pregnant.

___ I am depressed

___ I am sensitive to light and noise.

___ I am irritable and moody

___ I have a hard time concentrating.

___ I am clumsy.

HISTORY OF CAR ACCIDENT

- My vehicle was struck from the: Front __ Rear __ Right Side __ Left Side __
- Compared to my car, the striking vehicle was: Bigger __ Smaller __ The Same Size __
- The surface of the road was: Dry Payment __ Wet Payment __
  Icy Pavement __ Gravel __ Dirt __ Mud __
- The collision moved my vehicle: a little __ more than a little __ a lot __
- The amount of damage to my vehicle was: small __ quite a bit __ extensive __

At the time of the collision:

- I was: The Driver __ A Front-seat Passenger __ Back-seat Passenger __
- My seat was: Slightly titled __ Not titled __
- My seat: Had a Headrest __ Didn't Have A Headrest __
- The top of my headrest was: Below The Top Of My Head __
  Above The Top Of My Head __ Even With The Top Of My Head __
- The distance between my head and my headrest was: Less Than 25 mm __
  Between 25 and 50 mm __ More than 50 mm ___
- The collision: Caught Me By Surprise __ Didn't Catch My By Surprise __
- I was restrained by: A Lap Belt __ Shoulder/lap Belt Combination __
  An Air Bag __ Wasn't Restrained __
- I was looking: Straight Ahead __ Down __ Down To The Right __ Down To The Left __
  Up __ Up To The Left __ Up To The Right __ To The Left __ To The Right __

If any part of your body hit something please write the body part and the object it hit or check N/A for non applicable: ___ N/A _____

_____

List any articles in the car that moved because of the collision, such as glasses etc. or check N/A **for non applicable:** ___ N/A _____

_____

After the collision:

- I was: Fine __ Confused __ In Pain __ Emotional __

(For Doctor)_____

- I went: Home __ To Dr. _____ __ To The _____ Hospital
- I left the accident scene by: Ambulance __ Driving My Car __ Riding In My Car __ Riding In Another Car __

Because of this accident:

- I have seen the following for treatment: No One __

___A Medical Doctor (Name) _____

___ A Chiropractor (Name) _____

___ A Physical Therapist (Name) _____

___ A (Specialty) _____ (Name) _____

- I am: Taking No Medication __ Taking Medication __

History of Prior Trauma:

- ___ Has never been in an accident prior to this accident.
- List the dates you have been in car accidents involving other cars and if you were hurt::

Dates: _____

(For Doctor) _____

- List the dates you have been in car accidents involving other obstacles such as trees, bridges, or animals, and if you were hurt::

Dates: _____

(For Doctor) _____

- List any trauma other than those related to car accidents and if you were hurt:

Dates: _____

(For Doctor) _____

List and Describe Your Complaints From This Accident:

1. **Complaint:** _____

How soon after the accident were you first aware of this complaint? _____

If you have had this complaint before, when and why did you experience it and how is it different after this accident? _____

_____

What makes this complaint better? _____

What makes this complaint worse? _____

Describe the complaint: Achy___ Dull ___ Sharp ___ Tingling ___ Numbness ___

Restricted Movement ___ Other _____

What time of the day do you experience the complaint the most? Wake up ___ Morning ___

Afternoon ___ Evening ___ Bedtime ___

Describe the frequency of pain: Off and On ___ Constant ___

Does pain from the complaint travel to other areas? Yes ___ No ___

If yes, where does it travel to: _____

How do you treat the complaint? Medication ___ Ice ___ Heat ___ Rest ___ Doctor ____

Other _____

2. **Complaint:** _____

How soon after the accident were you first aware of this complaint? _____

If you have had this complaint before, when and why did you experience it and how is it different after this accident? _____

_____

What makes this complaint better? _____

What makes this complaint worse? _____

Describe the complaint: Achy___ Dull ___ Sharp ___ Tingling ___ Numbness ___

Restricted Movement ___ Other _____

What time of the day do you experience the complaint the most? Wake up ___ Morning ___

Afternoon ___ Evening ___ Bedtime ___

Describe the frequency of pain: Off and On ___ Constant ___

Does pain from the complaint travel to other areas? Yes ___ No ___

If yes, where does it travel to: _____

How do you treat the complaint? Medication ___ Ice ___ Heat ___ Rest ___ Doctor ____

Other _____

3. **Complaint:** _____

How soon after the accident were you first aware of this complaint? _____

If you have had this complaint before, when and why did you experience it and how is it different after this accident? _____

_____

What makes this complaint better? _____

What makes this complaint worse? _____

Describe the complaint: Achy___ Dull ___ Sharp ___ Tingling ___ Numbness ___

Restricted Movement ___ Other _____

What time of the day do you experience the complaint the most? Wake up ___ Morning ___

Afternoon ___ Evening ___ Bedtime ___

Describe the frequency of pain: Off and On ___ Constant ___

Does pain from the complaint travel to other areas? Yes ___ No ___

If yes, where does it travel to: _____

How do you treat the complaint? Medication ___ Ice ___ Heat ___ Rest ___ Doctor ____

Other _____

4. **Complaint:** _____

How soon after the accident were you first aware of this complaint? _____

If you have had this complaint before, when and why did you experience it and how is it different after this accident? _____

_____

What makes this complaint better? _____

What makes this complaint worse? _____

Describe the complaint: Achy___ Dull ___ Sharp ___ Tingling ___ Numbness ___

Restricted Movement ___ Other _____

What time of the day do you experience the complaint the most? Wake up ___ Morning ___

Afternoon ___ Evening ___ Bedtime ___

Describe the frequency of pain: Off and On ___ Constant ___

Does pain from the complaint travel to other areas? Yes ___ No ___

If yes, where does it travel to: _____

How do you treat the complaint? Medication ___ Ice ___ Heat ___ Rest ___ Doctor ____

Other _____

5. **Complaint:** _____

How soon after the accident were you first aware of this complaint? _____

If you have had this complaint before, when and why did you experience it and how is it different after this accident? _____

_____

What makes this complaint better? _____

What makes this complaint worse? _____

Describe the complaint: Achy___ Dull ___ Sharp ___ Tingling ___ Numbness ___

Restricted Movement ___ Other _____

What time of the day do you experience the complaint the most? Wake up ___ Morning ___

Afternoon ___ Evening ___ Bedtime ___

Describe the frequency of pain: Off and On ___ Constant ___

Does pain from the complaint travel to other areas? Yes ___ No ___

If yes, where does it travel to: _____

How do you treat the complaint? Medication ___ Ice ___ Heat ___ Rest ___ Doctor ____

Other _____

6. **Complaint:** _____

How soon after the accident were you first aware of this complaint? _____

If you have had this complaint before, when and why did you experience it and how is it different after this accident? _____

_____

What makes this complaint better? _____

What makes this complaint worse? _____

Describe the complaint: Achy___ Dull ___ Sharp ___ Tingling ___ Numbness ___

Restricted Movement ___ Other _____

What time of the day do you experience the complaint the most? Wake up ___ Morning ___

Afternoon ___ Evening ___ Bedtime ___

Describe the frequency of pain: Off and On ___ Constant ___

Does pain from the complaint travel to other areas? Yes ___ No ___

If yes, where does it travel to: _____

How do you treat the complaint? Medication ___ Ice ___ Heat ___ Rest ___ Doctor ____

Other _____

LIFE STYLE ACTIVITIES

Use the following checklist to indicate the activities which have affected your everyday duties. Select a number that represents the area that these activities aggravate: **1 = neck, 2 = mid back, 3 = low back, 4 = extremities,**

Domestic (in the house duties)

___ arranging flowers
___ changing light bulbs
___ cleaning
___ cooking
___ folding laundry
___ hanging pics etc
___ holding bowls etc
___ lifting
___ moving items
___ polishing
___ setting table
___ shampooing rugs
___ vacuuming

Household (out of house)

___ changing oil in car
___ changing tires
___ cleaning gutters
___ cleaning interior car
___ cleaning pool
___ clearing brush
___ fertilizing
___ hammering
___ mowing grass
___ painting
___ pruning
___ raking/bagging leaves
___ scraping walls
___ shoveling driveway
___ spackling
___ spraying
___ taking out trash
___ tree trimming
___ using drills
___ using tools
___ walking dog
___ washing car
___ watering lawn
___ weeding

Hobbies

___ building models
___ camping
___ crocheting
___ fishing
___ knitting
___ music instruments
___ painting
___ photography
___ motorcycling
___ reading
___ sailing
___ sewing

(personal)

___ applying makeup
___ bathing
___ brushing teeth
___ combing hair
___ flossing
___ gargling
___ hair treatments
___ nail care
___ shampooing
___ shaving
___ showering
___ toilet care
___ hugging
___ kissing
___ sexaul intercourse