# ADVANTAGE *WALK-IN* CHIROPRACTIC

## Personal Injury History Form

**Instructions: Please carefully consider and answer each question as completely as possible**

Name (first & last) _____Today's Date _____Date of Accident _____

If this was an auto accident were you the ☐ Driver ☐ Passenger ☐ Pedestrian

If an auto collision, were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

☐ Other_____

Did your car strike the other(s) involved? ☐ Yes ☐ No. Did the car strike yours? ☐ Yes ☐ No

Were traffic tickets issued? ☐ Yes ☐ No. If "yes", to ☐ You ☐ The other driver ☐ The driver of your car

Did any part of your body strike any part of the car? ☐ Yes ☐ No. If "yes" please explain:_____

_____

Did you have your safety belt on? ☐ Yes ☐ No. Shoulder Strap? ☐ Yes ☐ No

Does your car have a headrest? ☐ Yes ☐ No. Height or Position? ☐ Shoulder ☐ Neck ☐ Head ☐ Above

Loss of consciousness? ☐ Yes ☐ No. If "yes" please explain:_____

_____

Were you stunned? ☐ Yes ☐ No. How long?_____

Did you heel or hear popping, tearing, or ripping noise in your neck or back? ☐ Yes ☐ No. If "yes," please explain:_____

_____

Did you feel any pain? ☐ Yes ☐ No. If "yes," where?_____

How long after the accident?_____

Did you find any bruises? ☐ Yes ☐ No. Where?_____

List the extent of injuries as you know them:_____

**Instructions: Please check symptoms you have experienced since the accident:**

| | | | |
|---|---|---|---|
| ☐ Headache | ☐ Low Back Pain | ☐ Face Flushed | ☐ Constipation |
| ☐ Skull or Head Pain | ☐ Low Pain Stiffness | ☐ Loss of Color | ☐ Excessive Perspiration |
| ☐ Neck Pain | ☐ Hip Pain | ☐ Dizziness | ☐ Loss of Perspiration |
| ☐ Neck Stiffness | ☐ Buttock Pain | ☐ Fainting | ☐ Loss of Taste |
| ☐ Head feels too Heavy | ☐ Leg Pain | ☐ Sinus Trouble | ☐ Cold Sweats |
| ☐ Shoulder Pain | ☐ Leg Numbness | ☐ Loss of Smell | ☐ Fever |
| ☐ Shoulder Stiffness | ☐ Pins and Needles in Legs | ☐ Eye Strain | ☐ Swelling, if so where: |
| ☐ Arm Pain | ☐ Numbness in Feet/Toes | ☐ Difficulty Focusing | ☐ Difficulty in: |
| ☐ Arm Numbness | ☐ Cold Feet | ☐ Pain Behind the Eyes | ☐ Prolonged |
| ☐ Pins and Needles in Arms | ☐ Depression | ☐ Eyes Sensitive to Light | ☐ Excesssive |
| ☐ Numbness in Hands/Fingers | ☐ Anxiety | ☐ Double Vision | ☐ Riding in car |
| ☐ Cold Hands | ☐ Tension | ☐ Buzzing or Ringing in Ears | ☐ Bending |
| ☐ Upper Back Pain | ☐ Irritability | ☐ Loss of balance | ☐ Standing |
| ☐ Upper Back Stiffness | ☐ Nervousness | ☐ Palpitations | ☐ Sitting |
| ☐ Mid Back Pain | ☐ Mental Dullness | ☐ Shortness of Breath | ☐ Walking |
| ☐ Mid Back Stiffness | ☐ Loss of Memory | ☐ Digestive Problems | ☐ Lifting |
| ☐ Chest Pain | ☐ Dificulty Sleeping | ☐ Nausea | ☐ Twisting/Turning |
| ☐ Rib Pain | ☐ Fatigue | ☐ Vomiting | ☐ Difficulty rising to walk |
| ☐ Painful Breathing | ☐ Tremors | ☐ Diarrhea | ☐ Pain doing occupation |

Did you require post accident care or hospitalization? ☐ Yes ☐ No. If "yes," where?_____

Were you examined? ☐ Yes ☐ No. If "yes," by whom?_____

Were you x-rayed? ☐ Yes ☐ No. Was any treatment given? (medication, supports, or recommendations)

_____

What is your occupation?_____ What duties are required of you on the job?_____

_____

Have you missed work as a result of this accident? ☐ Yes ☐ No. If "yes," how many days?_____

## Insurance Companies:

Your Insurance Company:_____ Ins. Adjustor Name:_____

Address:_____City:_____Sate:_____Zip:_____Phone:_____

Insurance of person responsible for the accident?_____Ins. Adjustor Name:_____

Address:_____City:_____Sate:_____Zip:_____Phone:_____

## Your Attorney:

Your Attorney's Firm:_____ Attorney Name:_____

Address:_____City:_____Sate:_____Zip:_____Phone:_____

_____

## PERSONAL INJURY CONSULTATION

Date of Accident:_____ Time:_____ (A.M.)(P.M.) Weather:_____ Road Conditions:_____

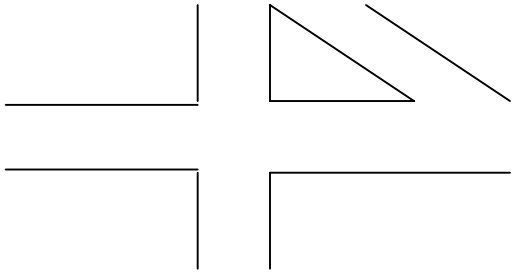
Street(s):_____ Street(s):_____

Patient Headed ( N S E W ) Other(s) Headed ( N S E W )

Patient Speed:_____ Other(s) Speed:_____

Patient Car Type:_____ Other(s) Car Type:_____

Patient Car Hit:_____ Other(s) Car Hit:_____



## Impact:

Body: (Straight/Bent/Twisted) (Rt/Lft) Head: (Neutral/Up/Down) (Rt/Lft) Breaking: (On/Off) Patient Awareness: (None/Partial/Very)

_____

_____

_____

## Immediate Post Impact:

_____

_____

_____

## First Aid

Passenger(s) / Passer(s) By / Police / Aid Care / Ambulance / Hospital / Clinic / Home Care

Name:_____ Location:_____ Assistance:_____

Comments:_____

Name:_____ Location:_____ Assistance:_____

Comments:_____

## Doctor(s) and Treatment

1._____ Specialty:_____ Diagnostics:_____

Diagnosis:_____ Treatment:_____ Results:_____

2._____ Specialty:_____ Diagnostics:_____

Diagnosis:_____ Treatment:_____ Results:_____

3._____ Specialty:_____ Diagnostics:_____

Diagnosis:_____ Treatment:_____ Results:_____

## Current Disabilities and Restrictions

Home:_____

_____

Work:_____

_____

Play:_____

_____

## Current Symptoms

| Symptoms | Onset | Frequency | Duration | Intensity | Prior |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |

## Previous Injuries/Accidents

_____

_____

_____

_____

_____