CENTRO
CHIROPRACTIC CLINIC

Centro Chiropractic Clinic

Today's Date _____

Patient Name _____ Date of Birth _____

Date of Accident: _____ Time of Accident: _____

Location of Accident _____

Brief Description of Accident: _____

_____

_____

_____

Accident Details

Your Vehicle information (year, make model): _____

Were you the: Driver, front passenger, rear passenger? _____

If you were the passenger, were you sitting on the : driver's side, passenger side, middle? _____

What was the Estimated Speed of your vehicle at the time of the accident? _____

What Type of accident was it? Rear-ended, side-impact , front collision, other? _____

The Other Vehicle(s) information: (year, make, model): _____

The Road Conditions at the time of the accident were: (dry, wet, rain, snow, other)? _____

What was the Estimated speed of the other vehicle: _____

What type of Headrest does your vehicle have: fixed, adjustable? _____

What position was the headrest in: lowest position, middle position, top position? _____

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Was your Seatback broken? **Yes** **No**

Did you use a: Shoulder/lap belt, lap belt only, carseat, no seatbelt used, other? _____

Did your Airbag deploy as a result of the accident? **Yes** **No**

If yes, were you struck by the airbag? **Yes** **No**

At the time of impact, what was your head position: facing forward, looking up, looking down, turned to the left, turned to the right, other. Explain:

_____

At the time of impact, what was the Position of your torso (upper body): facing forward, leaning back, leaning forward, turned to the left, turned to the right, other. Explain:

_____

Were you aware of the impending collision with the other vehicle? **Yes** **No**

Did you Brace for the impact? **Yes** **No**

Were your Hands on the steering wheel at the time of impact? **Yes** **No**
If yes, which hand(s): **both** **left only** **right only**

Was your Foot on the brake pedal at the time of impact? **Yes** **No**
If yes, was it knocked off the brake pedal due to the impact? **Yes** **No**

Did the collision move your vehicle? **Yes** **No**
If yes (how far)? _____ feet

Were you wearing hat, glasses, etc at the time of the collision? **Yes** **No**
If yes, were they knocked off? **Yes** **No**

Did any part of your body strike any object inside the car?
Yes **No**
If yes, explain: _____

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Did you lose consciousness after the accident? **Yes** **No**
If yes, for how long? _____

Describe the Damage to your vehicle: _____

What dollar amount did the body shop estimate the damage to be? _____

Describe the Damage to other vehicle(s) involved: _____

Did the Police respond to the accident? **Yes** **No**

Did they file a Report? **Yes** **No**

Did you file a DMV accident report? **Yes** **No**

Where did you go immediately after the accident? _____

How did you get there? _____

Did you go to the Hospital? **Yes** **No**

What hospital did you go to? _____

What was their diagnosis? _____

What body part(s) did they x-ray? _____

What other tests, exams did they do on you? _____

_____

What medications did they give you? _____

_____

Immediately after the accident symptoms:

Immediately after the accident were you: **dizzy, nauseous , vomiting , confused, disoriented, dazed**, other:

_____

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Did you feel pain immediately after the accident? **Yes** **No**
If yes, describe: _____

If you did not feel pain immediately after the accident, how long did it take until you began to feel pain?

_____

Where did you feel pain?_____

Do you or did you have any cuts or bruises from the accident? **Yes** **No**

If yes, explain:_____

Your Present Symptoms:

In this section, you will describe your current pain. You will list, separately, each part of your body that is in pain and you will answer some questions regarding the pain of that part of your body.

Example of body parts are: headaches, neck pain, upper back pain, mid back pain, low back pain, hip pain, knee pain, ankle pain, foot pain, shoulder pain, elbow pain, wrist pain, hand pain, chest pain, etc.

Body Part 1:_____

What makes the pain increase?: _____

What makes the pain decrease?: _____

Describe the type of pain you feel: _____

Does the pain stay in this body part, or does it radiate/move to another part of the body?

_____

On a scale of 0-10 with 0 representing absolutely no pain, and 10 representing the worst pain imaginable, what is your pain level **currently**? (circle your choice)

1 2 3 4 5 6 7 8 9 10

What is your pain level **usually**?: **1 2 3 4 5 6 7 8 9 10**

Is the pain: getting better with time, staying the same, getting worse with time?_____

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What percentage of your waking hours do you feel the pain (0-100%): _____

Does your pain vary throughout the day? (for example, worse at the end of the day) or is it constant?
Yes **No**
If your pain varies, explain:_____

_____

Body Part 2:_____

What makes the pain increase?: _____

What makes the pain decrease?: _____

Describe the type of pain you feel: _____

Does the pain stay in this body part, or does it radiate/move to another part of the body?:

_____

On a scale of 0-10 with 0 representing absolutely no pain, and 10 representing the worst pain imaginable, what is your pain level currently? (circle your choice)

1 2 3 4 5 6 7 8 9 10

What is your pain level usually?: **1 2 3 4 5 6 7 8 9 10**

Is the pain: getting better with time, staying the same, getting worse with time? **Yes** **No**

What percentage of your waking hours do you feel the pain (0-100%): _____

Does your pain vary throughout the day? (for example, worse at the end of the day) or is it constant?

If your pain varies, explain: _____

_____

Body Part 3:_____

What makes the pain increase?: _____

What makes the pain decrease?: _____

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Describe the type of pain you feel:

Does the pain stay in this body part, or does it radiate/move to another part of the body?:

On a scale of 0-10 with 0 representing absolutely no pain, and 10 representing the worst pain imaginable, what is your pain level currently? (circle your choice)

1 2 3 4 5 6 7 8 9 10

What is your pain level usually?: **1 2 3 4 5 6 7 8 9 10**

Is the pain: getting better with time, staying the same, getting worse with time?

If yes, explain: _____

What percentage of your waking hours do you feel the pain (0-100%):

_____

Does your pain vary throughout the day? (for example, worse at the end of the day) or is it constant?
Yes **No**
If your pain varies, explain: _____

Body Part 4:_____

What makes the pain increase?: _____

What makes the pain decrease?: _____

Describe the type of pain you feel: _____

Does the pain stay in this body part, or does it radiate/move to another part of the body?:

On a scale of 0-10 with 0 representing absolutely no pain, and 10 representing the worst pain imaginable, what is your pain level currently? (circle your choice)

1 2 3 4 5 6 7 8 9 10

What is your pain level usually?: **1 2 3 4 5 6 7 8 9 10**

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Is the pain: getting better with time, staying the same, getting worse with time? **Yes** **No**

What percentage of your waking hours do you feel the pain (0-100%): _____

Does your pain vary throughout the day? (for example, worse at the end of the day) or is it constant?

If your pain varies, explain: _____

_____

If, after the accident, you began to have any of the symptoms in this section, please explain in detail:

Weakness of your arm(s) or leg(s) **Yes** **No**

_____

Numbness of your arm(s) or leg(s) **Yes** **No**

_____

Tingling of your arm(s) or leg(s) **Yes** **No**

_____

Pain with swallowing food or liquids: **Yes** **No**

_____

Changes with your vision: **Yes** **No**

_____

Changes with your hearing: **Yes** **No**

_____

Vomiting: **Yes** **No**

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Bowel changes: **Yes** **No**

Bladder changes: **Yes** **No**

Is there any other change to your body that you feel may be a result of the accident?

Your Past Health History (please expain fully):

Do you have any Serious illnesses?

Have you been Hospitalized before?

Have you had any surgeries?

Have you experienced any previous physical Trauma? **Yes** **No**

Have you had any other accidents? **Yes** **No**

How many Pregnancies have you had?

Are you currently taking any Medications? **Yes** **No**

Do you have Allergies? **Yes** **No**

Have you ever had any X-rays before? **Yes** **No**

Have you seen a chiropractor before (if yes, name and city)?

When was your Last physical exam?

Do you have Any prior history of your current complaints/pains?

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Review of Symptoms: please circle and explain any of the symptoms you currently have

Fever fatigue night sweats chest pain Shortness of breath

abdominal pain chronic cough rashes unexplained weight loss nausea

Vomiting diabetes musculoskeletal disorders heart disease lung disease

Family Health History (of only your grandparents, parents, or siblings): (please circle and explain who had/has the condition, and how old they were when they first were diagnosed)

Anemiacancer diabetes heart disease high blood pressure

Epilepsy psychological disorders asthma kidney disease glaucoma tuberculosis

Your Personal/Social History

What is your occupation?_____

Are you Married? **Yes** **No**

What are the ages of your Children?_____

Describe your Diet:

_____

Do you Exercise regularly? **Yes** **No**

_____

Do you have Hobbies? **Yes** **No**

If yes, are you able to do your hobby since the accident? **Yes** **No**

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Do you drink Alcohol? **Yes** **No**

If yes, how much, how often? _____

Do you use Tobacco? **Yes** **No**

If yes, how much, and for how long? _____

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