Alpine Wellness Chiropractic
"Unlocking the Healer Within"

16205 West 64th Avenue, Ste 001
Arvada, CO 80007
(303) 431-8588

ADULT AUTOMOBILE ACCIDENT HISTORY FORM

Patient Name: _____ Date: _____

Date of Accident: _____ Time of Accident: _____

City of Accident: _____ Street of Accident: _____

What were the road conditions at the time of the accident: WET DRY ICY Other_____

How far is the top of the headrest or seatback from the top of your head (approximately)?

_____inches above or below

Were you wearing your seatbelt? Yes No

If yes, was it a lap seatbelt _____ or a shoulder-lap seatbelt _____

List the year, make, and model of the vehicle you were in:

Year _____ Make _____ Model _____

Was your car stopped at the time of impact? Yes No

If yes, was the driver's foot also on the brake? Yes No

If no, estimate the speed of the vehicle you were in: _____MPH

If your vehicle was moving at the time of impact, was it:

Slowing down? Yes No

Gaining speed? Yes No

Traveling at a steady rate of speed? Yes No

On what part of the automobile did your following parts hit?

Head hit _____ Chest hit _____

Right/Left shoulder hit _____ Right/Left arm hit _____

Right/Left hip hit _____ Right/Left leg hit _____

Right/Left knee hit _____ other _____

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?

Aware Surprise

Did you lose consciousness (black out) upon impact? Yes No How Long? _____

Did you experience a flash of light or explosion in your head? Yes No

Did the accident cause you to become: Confused Disoriented Light-Headed Dizzy

Nauseated Blurred Vision Ring/Buzz in ears

If you still have any of these symptoms, which ones? _____

Are you currently suffering from any of the following?

Restlessness	Irritable
Difficulty Concentrating	Difficulty with Memory
Sleeplessness	Forgetfulness
Reduced Tolerance to Heat	Reduced Tolerance to Alcohol

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Did the police come to the accident scene? Yes No

Is there a police report? Yes No

Did you go to the hospital? Yes No

If yes, what is the name and city of the hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

Did the airbag deploy? Yes No

Did you receive any injuries or bruises from the seatbelt or airbag? Yes No

If yes, please describe: _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? _____

Describe your body position at the time of impact?_____

What is the estimated cost of damage to the vehicle you were in? _____

Which of the following car parts broke during the accident?

Windshield Front Seatback

Right/Left Side Window Other _____

Steering Wheel Other _____

What is the year, make and model of the other vehicle?

Year _____ Make _____ Model _____

Was the other vehicle moving at the time of the collision? Yes No

If yes, what was its approximate speed? _____MPH

Was it: Slowing Down Gaining Speed Traveling at a Steady Speed

Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

_____

_____

_____

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MEDICAL HISTORY FORM

In chronological order, please answer the following about the doctors who have treated you for injuries sustained in the auto accident. **Complete one sheet for each doctor or provider.** (paramedic, hospital ,MD, DC, therapist, etc.)

Provider's Name: _____

1. Approximate dates of service: From: _____ To: _____
2. What symptoms (pain) did you have when you consulted this doctor?

   _____

   _____

   _____
3. Did the doctor examine you? Yes No
4. Were x-rays taken? Yes No
5. Were any special tests performed? Yes No

   Please give date: MRI _____ CT _____

   EMG _____ Other _____
6. What was the doctor's diagnosis? (What did he/she say was wrong with you?)

   _____

   _____
7. What treatment have you received:

   Spinal Adjustments Hot Packs Cold Packs Diathermy Ultrasound

   Electric Muscle Stim. Traction Exercise Medication Surgery

   Other (list) _____
8. How many treatments have you received? (number of visits) _____
9. How often do you see the doctor now? _____
10. How long does the treatment take? _____
11. Do you, or the doctor, decide when your next appointment will be? _____
12. Did this doctor's treatment help you? Yes No

    If yes, how much? (please give percent of improvement) _____
13. How long does the benefit last? _____

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PAST MEDICAL HISTORY (prior to this accident)

1. Have you ever been treated by a chiropractor prior to this auto accident? Yes No

   If yes, for what? _____

2. Have you been in any previous auto accidents? Yes No

   If yes, for each give the year, a brief description of any injuries, and remaining effects.

   _____

   _____

   _____

3. Did you recover completely from your prior injury oe physical problem? Yes No

   If yes, when? _____

   If no, explain: _____

4. Prior to this accident, did you have any physical limitations? Be specific (e.g. limited lifting, bending, sitting, stooping,, squatting, pushing, pulling, climbing _____

   _____

5. Do you have any disability awards? Yes No

   If yes, what percentage? _____

   For what area of the body was your disability given? _____

6. Do you take prescription or over-the counter medications? Yes No

   If yes, name the drug, the purpose of the drug, and the name of the prescribing doctor

   _____

   _____

   _____

WORK HISTORY (related to the accident)

1. Describe you job and title: _____
2. Have you missed work as a result of the accident? Yes No

   If yes, give dates_____
3. Date returned to work? _____
4. As a result of the accident, is there any part of your job that you can't presently do? Yes No

   If yes, list limitations or things you can't do. Be specific (e.g. limited or precluded from lifting, bending, stooping,, squatting, twisting, pushing, pulling, reaching or other physical activity) _____

   _____

   _____