# Motor Vehicle Accident History

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|---|---|---|---|
| PATIENT NAME: | | | DATE: |
| ADDRESS: | | CITY: | STATE/ZIP CODE: |
| HOME PHONE NUMBER: | | CELL PHONE NUMBER: | |
| SOCIAL SECURITY NUMBER: | DATE OF BIRTH: | AGE: | GENDER: |
| EMERGENCY CONTACT NAME: | | EMERGENCY CONTACT PHONE NUMBER: | |
| EMPLOYER NAME: | | EMPLOYER ADDRESS: | |

## ACCIDENT INFORMATION

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| DATE OF ACCIDENT: | TIME OF ACCIDENT: | WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT?<br>❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT |
| NUMBER OF PEOPLE IN THE CAR: | NAMES OF PEOPLE IN THE CAR WITH YOU: | |

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| WHAT DIRECTION WAS YOUR CAR HEADED?<br>❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST | ON WHAT STEET WERE YOU HEADED? |
| WHAT DIRECTION WAS THE OTHER CAR HEADED?<br>❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST | WERE YOU STRUCK FROM:<br>❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE |
| WERE YOU KNOCKED UNCONSCIOUS?<br>❑ YES ❑ NO | DID YOU HIT YOUR HEAD?<br>❑ YES ❑ NO |

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| WHERE WERE YOU TAKEN AFTER THE ACCIDENT? | BY AMBULANCE:<br>❑ YES ❑ NO |

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| WERE THE POLICE ON THE SCENE?<br>❑ YES ❑ NO | WAS A REPORT FILED?<br>❑ YES ❑ NO | DO YOU HAVE A COPY?<br>❑ YES ❑ NO |

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| HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT?<br>❑ YES ❑ NO | SINCE THE INJURY, ARE YOUR SYMPTOMS:<br>❑ IMPROVING ❑ GETTING WORSE ❑ GETTING BETTER |

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|---|---|---|
| HAVE YOU LOST TIME FROM WORK?<br>❑ YES ❑ NO | DATE YOU LEFT WORK: | DATE YOU RETURNED TO WORK: |
| HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST?<br>❑ YES ❑ NO | IF YES, PLEASE DESCRIBE: | |
| DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE?<br>❑ YES ❑ NO | IF YES, PLEASE DESCRIBE: | |
| DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY?<br>❑ YES ❑ NO | IF YES, PLEASE DESCRIBE: | |

## INSURANCE INFORMATION

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|---|---|
| AUTO INSURANCE COMPANY NAME: ❑ Your Policy ❑ Person at Fault's Policy | |
| ADJUSTER NAME: | ADJUSTER PHONE NUMBER: |
| POLICY NUMBER: | CLAIM NUMBER: |

## ACCIDENT INFORMATION

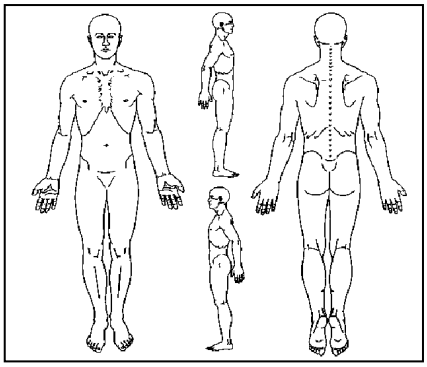
DESCRIBE THE ACCIDENT IN YOUR OWN WORDS:

INSTRUCTIONS: *CHECK (✓) ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.*

- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ SLEEPING PROBLEMS
- ❑ BACK PAIN
- ❑ NERVOUSNESS
- ❑ TENSION
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ FEVER
- ❑ DIZZINESS
- ❑ HEAD SEEMS HEAVY
- ❑ PINS & NEEDLES IN ARMS
- ❑ PINS & NEEDLES IN LEGS
- ❑ NUMBNESS IN FINGERS
- ❑ NUMBNESS IN TOES
- ❑ SHORTNESS OF BREATH
- ❑ FATIGUE
- ❑ DEPRESSION
- ❑ FEET FEEL COLD
- ❑ HANDS FEEL COLD
- ❑ COLD SWEATS
- ❑ LIGHT BOTHERS EYES
- ❑ LOSS OF MEMORY
- ❑ EARS RING
- ❑ FACE FLUSHED
- ❑ BUZZING IN EARS
- ❑ LOSS OF BALANCE
- ❑ FAINTING
- ❑ LOSS OF SMELL
- ❑ LOSS OF TASTE
- ❑ UPSET STOMACH
- ❑ OTHER: _____
- ❑ OTHER: _____

**INTRUCTIONS:** *Please mark the area and type of pain on the drawings using the codes listed below:*

**N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness**



COMMENTS:

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

## DOCTOR ONLY

DOCTOR COMMENTS:

## SIGNATURE

| PATIENT SIGNATURE: | DATE: |
|---|---|
| | |

**Health Link Family Chiropractic**
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