

Auto Accident History Form

Patient's Name _____ Today's Date _____ DOB _____ Date of Injury _____
Patient Address _____
Phone (H) _____ (C) _____ Email _____
Insurance Company _____ Insurance Company Contact Name _____
Claim # _____ Ins. Ph. # _____ Fax # _____

General information

Marital status: married single divorced widowed separated partnered

Smoke: none pack/day _____ years

Alcohol: none # drinks _____ per day/week/month

Employment status

At time of accident, where did you work? _____ Unemployed
Where do you currently work? _____ Unemployed
If unemployed, is it due to injuries from the accident? yes no
What activities does your work require? _____

Accident details	Accident diagram:
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You were: <input type="checkbox"/> driver <input type="checkbox"/> front passenger <input type="checkbox"/> rear passenger <input type="checkbox"/> pedestrian <input type="checkbox"/> bicyclist	General Description of Accident:
Your vehicle(yr./make/model) _____	
Your estimated speed at time of accident: <input type="checkbox"/> stopped <input type="checkbox"/> slowing <input type="checkbox"/> accelerating	
Location/street _____	
Direction of travel: <input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W	
Impact came from: <input type="checkbox"/> front <input type="checkbox"/> rear <input type="checkbox"/> L <input type="checkbox"/> R other _____	
Other vehicle(yr./make/model) _____	
Time of day _____	
Road conditions: <input type="checkbox"/> dry <input type="checkbox"/> damp <input type="checkbox"/> wet <input type="checkbox"/> icy <input type="checkbox"/> snow	
Body position at impact: Head: <input type="checkbox"/> forward <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> up <input type="checkbox"/> down Body: <input type="checkbox"/> forward <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> up <input type="checkbox"/> down	
Head rest position: <input type="checkbox"/> up <input type="checkbox"/> down <input type="checkbox"/> don't know	
Lap belt: <input type="checkbox"/> on <input type="checkbox"/> off Shoulder harness: <input type="checkbox"/> on <input type="checkbox"/> off	
Aware of impending crash? <input type="checkbox"/> Y <input type="checkbox"/> N	
Was seat broken by impact? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Was your vehicle equipped with an airbag? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, did it inflate? <input type="checkbox"/> Y <input type="checkbox"/> N Were you struck by the airbag? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, where were you struck? _____	

During the accident

Did you strike any parts of the vehicle? Y N If yes, describe. _____
Did your vehicle strike any objects after initial impact? Y N If yes, describe. _____
Was your vehicle pushed in any direction by the impact? Y N If yes, describe. _____
Were you wearing a hat or glasses before impact? Y N If yes, were they still on after the impact? Y N
Did the accident render you unconscious? Y N If yes, how long? _____
Were the police on the scene? Y N Was an accident report filed? Y N
Estimated property damage to your vehicle. \$ _____
Estimated property damage to other vehicle. None Mild Moderate Major

After the accident

Please describe how you felt immediately after the accident: _____

Were you seen by a doctor or did you go to a hospital after the accident? Y N When did you go? Just after the accident The next day _____ days later How did you get there? Ambulance Private transportation _____

After the accident---continued

Name of hospital and/or attending doctor: _____

Were X-rays taken? Y N _____ Was medication prescribed? Y N _____

Have you been able to work since the injury? Y N _____ Are your work activities restricted as a result of your injuries? Y N _____

Please indicate with a check mark, all of the symptoms which you feel are a result of this accident. In the columns to the right, fill in the appropriate information for each of the symptoms you checked.

Symptoms	How long after accident did symptoms begin?	Is this condition getting worse?	How frequent are the symptoms?	-Rate the Discomfort from 0-10 (0=no pain, 10=worst pain ever) -And describe the type of the pain
<input type="checkbox"/> Neck pain		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Headache		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Memory loss		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Blurred vision		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Ears ringing		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Neck stiff		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Difficulty sleeping		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Numb hands/fingers		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Jaw problems		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Mid-back pain		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Low back pain		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Leg pain		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Numb feet/toes		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Tingling in extremities		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Nausea		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Irritability		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Chest pain		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Shortness of breath		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Confusion		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Difficulty swallowing		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
<input type="checkbox"/> Disorientation		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	

Who have you seen <u>for this condition</u>	Office use in this column
Doctor's name/specialty: _____	Dx: _____
Address: _____	Tx: _____
City: _____ State: _____ Zip: _____	X-rays/Tests: _____ Freq.: _____ Dur.: _____
Currently treating? _____ May we contact this Dr.? _____	Referred to/from: _____
Doctor's name/specialty: _____	Dx: _____
Address: _____	Tx: _____
City: _____ State: _____ Zip: _____	X-rays/Tests: _____ Freq.: _____ Dur.: _____
Currently treating? _____ May we contact this Dr.? _____	Referred to/from: _____
Provide descriptions and dates of all <u>past</u> injuries or conditions:	these include: fractures, dislocations, concussions, surgeries, major injuries or illness, sprains, hospitalizations, accidents, chronic issues

Name _____ Date _____

Please check each of the symptoms that apply to you:

- Attention/concentration challenges (mind wanders, easily distracted, difficulty focusing)
- Short-term memory loss, forgetfulness or trouble learning new things
- Difficulty finding the right word when speaking
- Difficulty making decisions or solving problems
- Difficulty understanding what is said or read
- Difficulty planning or organizing
- Make more mistakes than usual or not catching your mistakes
- Getting lost or disoriented even in familiar places
- Difficulty alternating attention or “juggling” several things at once
- Disorganized or confused thinking

- Dizziness
- Periods of “blacking out” or seizures
- Problems coordinating hands, feet, legs or dropping things
- Lose balance easily
- Stuttering or slurring
- Change in sense of taste or smell
- Blurry or double vision
- Ringing in the ears
- Headaches
- Greater than normal fatigue
- More sensitive to light and/or loud noise
- Tingling or numbness in arms or legs

- Feelings of sadness or depression
- Crying spells or weepiness
- Suicidal thoughts or intentions
- Increased or decreased emotions (circle appropriate answer)
- Increased or decreased appetite (circle one)
- Decreased interest in “fun” activities
- Difficulty with sleeping- getting to or staying asleep
- Increased irritability or easily frustrated
- Feelings of fear or anxiety

Consent Form, Business Agreement, Insurance Information

1. Consent to Treatment

The nature of Chiropractic care is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use her hands or tools to adjust your joints and align your soft tissues. You may hear a “click or pop”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, massage, Craniosacral therapy, traction, taping and exercise/nutritional instruction may also be employed.

There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Though we take every precaution, there are some risks associated with Chiropractic. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities includes muscular stain, ligamentous strain, and fractures. Injury to the intervertebral discs, nerves or spinal cord is possible, though are considered even less likely. The risks involved with treating the neck may include any of these, but also includes the remote possibility of cerebrovascular injury or stroke. Current literature states the chances of this occurring to be one in one million to one in ten million. The ancillary physical therapy procedures could produce skin irritations, burns or bruising. Other treatment options may include over the counter analgesics, which carry with them the risks of irritation to the stomach, liver, kidneys, and various other side effects.

This consent form is intended to cover the entire course of treatment for my present conditions, and any future conditions for which I may seek treatment at this office. I accept the risks and benefits, and hereby give my full consent to treatment.

2. Privacy Policy

I understand that Dr. Desbrow may disclose health information about me for purposes of treatment, payment or health care procedures. I have the right to receive a written Notice of Privacy Practices should I request it.

3. Cancellation and No Show Policy

I understand that without giving Dr. Desbrow 24 hours notice to cancel or change an appointment, full payment for the missed appointment will be due prior to my next appointment.

4. Release of Records/Payment Policy

Full payment is expected at the time of service. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangement may be made to omit payment to await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to six months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize the doctor to release my medical records relating to claim for benefits submitted.

Signature of Patient or Guardian _____

Date _____

Patient Name (please print) _____