Health First Chiropractic Clinic, P.C.
"Caring for Your Health First"

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Automobile Accident History

General Information

Date: _____
Name: _____ Date of Birth: _____ Age: _____ M F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
SS#: _____ Driver's License #: _____
How did you hear about our office? _____

Insurance Information

Please be aware until this information is supplied, all costs will be patient responsibility.

Insurance Company: _____
Name on Policy: _____
Policy Number: _____
Claim Number: _____
Insurance Claim Adjustor: _____
Insurance Phone Number: _____
Insurance Address: _____

Are there any other insurance policies active? Yes No
If yes, please name: _____
Do you live with any relative who owns a car? Yes No
If yes, please name: _____

Symptoms

Please answer these questions for your condition at the time of the accident.

Did you hit any part of your body during the collision? Yes No
If yes, which part and how? _____
Where did you feel pain? _____
Were you hospitalized? Yes No
If yes, how long and where? _____
If no, where were you taken? _____
Have you received any other care? Yes No
If yes, where and what type of care? _____
_____

Accident History

Today's Date: _____
Date of Accident: _____ Time of Accident: _____
State how the accident happened in your own words: _____
_____
_____
_____
What type of vehicle were you in? Make: _____Year: _____
Is the car in your name? Yes No
If no, whose name is it in? _____
Were you driving? Yes No
If no, where were you seated? _____
Was your seatbelt on? Yes No
Shoulder harness on? Yes No
Were you reclined? Yes No
Were there other people in the car? Yes No
If yes, please name: _____
Where they injured? Yes No
If yes, please explain:_____

Was it: Dawn Daylight Dusk Night
What were the weather conditions? _____
Were you tired? Yes No
Were you awake? Yes No
Where were you prior to the accident? _____
What were the traffic conditions? _____
Type of Road: 2 Lane 4 Lane Gravel Tar
What was the posted speed limit? _____ How fast were you going? _____
Did it happen at a/an: Stop Sign Traffic Light Intersection Highway

Was your car hit? Yes No
If yes, where: _____
Was there damage? Yes No
If yes, where?_____
Did your car strike anything? Yes No
If yes, please name: Another vehicle Sign Tree Other: _____
If another vehicle:
What type of vehicle? Make: _____ Year: _____
Was the other vehicle damaged? Yes No
If yes, where? _____
Were you conscious after impact? Yes No
Do you remember the impact? Yes No
Did your vehicle leave the road? Yes No
If yes, please explain: _____
Please provide photos of the accident if possible.
Was an accident report made? Yes No
If yes, by Police of: City: _____ County: _____ State: _____
Please provide a copy of the Police Report if possible.
Was a ticket issued? Yes No
If yes, to whom? _____ For?_____

Have you had any time loss from work? Yes No If yes, list dates: _____
Have you had to seek outside help? Yes No If yes, name: _____

Medical affidavit: I do attest that the above information is correct and true to the best of my knowledge

Patient Signature: _____ *Date:* _____

Family, Social, and Health History

Please Circle all the signs and symptoms you have or are concerned with on a **regular basis**. A complete history and understanding of your health status will help us to better facilitate care.

General Symptoms			
Wheezing	Fever	Night Sweats	Fainting
Dizziness	Nervousness	Convulsions	Fatigue
Loss of Weight	Numbness/Pain in arms/legs or hands/ feet	Headache of Migraine	Chills

Gastro-Intestinal			
Nausea	Poor Digestion	Hemorrhoids	Vomiting
Gall Bladder Trouble	Constipation/ Diarrhea	Pain over stomach	Belching or Gas
Colon Trouble	Liver Trouble	Excessive Hunger	Poor Appetite

Eye, Ear, Nose, and Throat			
Earache	Sinus Trouble	Poor Vision	Asthma
Sore Throat	Hoarseness	Nasal Obstruction	Nose Bleeds
Hoarseness	Enlarged Thyroid	Tonsillitis	Deafness

Genito-Urinary			
Frequent Urination	Painful Urination	Blood in Urine	Kidney Infection
Bed Wetting	Inability to Control Urine	Prostrate Trouble (Men Only)	

Muscles & Joints			
Weakness	Twitching (Spasms)	Stiff Neck	Back Pain
Swollen Joints	Tremors	Foot Trouble	Hernia

Cardiovascular			
Irregular Heartbeat	High or Low Blood Pressure	Pain over Heart	Varicose Veins
Poor Circulation	Swelling of ankles/ Edema	Heart Disease	History of Stroke

Skin		
Ace	Itching	Bruising Easily
Sensitive Skin	Hives	Eczema

Respiratory		
Chronic Cough	Spitting Blood	Spitting Phlegm
Chest Pain	Trouble Breathing	

Women Only			
Miscarriage	Painful Periods	Irregular Cycles	Hot Flashes
Cramps or Backaches	Pregnant (Due Date: _____)	Excessive Flow	Vaginal Discharge

Do you have/had any of the following?				
Diabetes	Chicken Pox	Multiple Sclerosis	Vaccinations	Gall Bladder
Anemia	Cancer (_____)	Mumps	Epilepsy	Thyroid
HIV/Aids	Lupus	Rheumatic Fever	Arthritis	Alcoholism
Polio/Measles	Tuberculosis	Sinus Surgery	Hernia	Stomach/Ulcer

Family History (Please list type)				
	Diabetes	Heart	Cancer	Arthritis
Mother				
Father				
Siblings	B, S	B, S	B, S	B, S

Work Activity
Sitting (__ Hrs/Day)
Standing (__ Hrs/Day)
Light Labor
Heavy Labor

Habits
Smoking (__ Packs/Day)
Alcohol (__ Drinks/Wk)
Caffeine (__ Cups/Day)
High Stress

Exercise
None
Light (__ Hrs/Wk)
Moderate (__ Hrs/Wk)
Heavy (__ Hrs/Wk)

List any accidents or falls: _____

List any surgeries, spinal taps or injections?_____:_____

Have you had any broken bones or fractures? Yes No If yes, list: _____

Has your social life been affected from this? Yes No If yes, list: _____

Have you previously seen a Chiropractor? Yes No If yes, whom? _____

How were you were referred to our office? _____

Medical Affidavit: I do attest, that the above information is correct and true to the best of my knowledge.

Patient Signature: _____ Date:_____

Reviewed & Consulted by (Physician Signature): _____

#_____