Synchrony ChiroCare
Harmony of Structure and Function

Motor Vehicle Crash History

Please Print

Patient Information

Acct#_____

Name _____ Address _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: ○ M ○ F Marital Status: ○ M ○ S ○ D ○ W

Email Address: _____

Social Security Number: _____ Primary Care Physician: _____

Females; are you pregnant? ○ Y ○ N Date of Last Menstrual Cycle: _____

Have you ever received chiropractic care in the past? ○ Y ○ N Last Date Treated:_____

Employer

Occupation: _____ Employer: _____

Employer Address _____ City _____ State _____ Zip Code _____ Employer Phone _____

Spouse

Spouse's Name _____ Spouse's Employer _____ Occupation _____

Children and Ages: _____

Emergency Contact

Name _____ Address _____

City _____ State _____ Zip Code _____

Contact phone: _____ Cell Phone: _____

Crash/Injury History

1. Date of Crash: _____ Time of Day:_____ Road Condition: ○ Dry ○ Wet
2. Were you: ○ Driver ○ Passenger ○ Front Seat ○ Back Seat
3. Number of people in your vehicle? _____
4. Were you wearing a seat belt? ○ Y ○ N (If no, Skip the next question)
5. If yes, were you wearing a lap belt? ○ Y ○ N Lap belt and shoulder harness? ○ Y ○ N
6. What direction were you headed? ○ North ○ South ○ East ○ West *If you are not sure, leave direction questions blank.*
   On (name of street and city): _____
7. What direction was the other vehicle headed? ○ North ○ South ○ East ○ West
   On (name of street and city): _____

8. Were you struck from: ○ Behind ○ Front ○ Left Side ○ Right Side
   Other combination, please describe: _____

9. What was the position of your head during the crash?
   ○ Straight Ahead ○ Turned Right ○ Turned Left ○ Other _____

10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc.)? ○ Y ○ N
    If yes, please explain: _____

11. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)? ○ Y ○ N
    If yes, please describe: _____

12. If your vehicle was equipped with air bags, did they activate? ○ Y ○ N

13. Make/model of your car: _____ Make/model of the other vehicle: _____

14. Were the police notified? ○ Y ○ N Please provide this office with a copy of the police report.

15. In your own words, please describe the accident: _____
    _____
    _____

16. Did you have any physical complaints BEFORE the accident? ○ Y ○ N
    If yes, please describe in detail: _____
    _____

17. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

18. Did you lose consciousness during the crash? ○ Y ○ N If yes, for how long? _____

19. Where were you taken after the accident? _____

20. Have you been treated by another doctor since this accident? ○ Y ○ N
    If yes, please list the doctor's name and address: _____
    What type of treatment did you receive? _____
    _____

21. Did this accident occur while you were performing your regular job duties? ○ Y ○ N

22. How do you feel now, what is your number-one problem or the one area of greatest pain? _____
    _____
    _____

23. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.
    0 1 2 3 4 5 6 7 8 9 10

24. Since this injury occurred, is your pain: ○ Improving ○ Getting Worse ○ Staying the Same

25. How often do you experience the pain?
    ○ 1-2 hours per day ○ About half of the day ○ Most of the day ○ The pain never goes away

26. How does the pain affect your daily activities?
    - ○ It does not affect my daily activities
    - ○ I have had to change how I do things
    - ○ I have had to stop doing some of my daily activities
    - ○ I am unable to perform daily activities

27. What increases your pain? _____

28. What decreases your pain? _____

29. Have you ever experienced this problem before? O Y O N When? _____

30. Do you have a previous illness/disease which affects your present condition? O Y O N If yes, please describe?
    _____

31. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.
    _____ 0 1 2 3 4 5 6 7 8 9 10
    _____ 0 1 2 3 4 5 6 7 8 9 10
    _____ 0 1 2 3 4 5 6 7 8 9 10
    _____ 0 1 2 3 4 5 6 7 8 9 10

32. Have you lost time from work as a result of this accident? O Y O N
    a. Type of employment: _____
    b. Last day worked: _____

33. Have you ever been involved in an accident before? O Y O N
    a. If yes, when? _____
    b. Describe the accident(s): _____
    c. _____
    d. Were you injured? O Y O N Explain: _____
    _____

34. List all medication you are currently taking (prescribed and over the counter) _____
    _____

35. List all surgeries you have had (with date) _____
    _____

If you have experienced any of the following conditions in the past, mark a "P" on the line provided. If you are currently experiencing any of the following conditions, please mark a "C" on the line provided. (check all that apply)

__ heart attack
__ diabetes
__ difficulty with urination
__ prostrate trouble
__ AIDS
__ dizziness
__ constipation
__ nausea
__ ears ringing
__ gout
__ knee/hip replacement
__ broken bones (specify) _____

__ stroke
__ glaucoma
__ anemia
__ ulcers
__ loss of memory
__ diarrhea
__ muscle cramping
__ headache
__ tuberculosis
__ arthritis
__ fainting spells

__ bloody stools
__ cancer
__ diverticulosis
__ chest pain
__ general fatigue
__ soreness in joints
__ migraine
__ syphilis
__ gall bladder trouble
__ kidney stones
__ tobacco use

__ difficulty w/bowel movements
__ asthma
__ menstrual cramping
__ shortness of breath
__ sudden weight loss
__ loss of hearing
__ epilepsy
__ sprained ankle
○ R ○ L

General Activities (check all that apply)

- sleep on waterbed
- read in bed
- fall asleep in recliner / on couch
- sleep on stomach
- needlepoint/ knitting
- use two or more pillows to sleep with
- sewing
- lift weights / weight machine
- play video games (__ hrs per day)
- exercise ___ x/wk.
- jog ___x/wk.
- computer use (__ hrs per day)
- swim
- use treadmill / elliptical machine
- watch television (__ hrs per day)

Please add anything else you would like the doctor to know: _____

_____

_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____
(signature of parent if the patient is a minor)

Synchrony ChiroCare

Harmony of Structure and Function

Pain Diagram

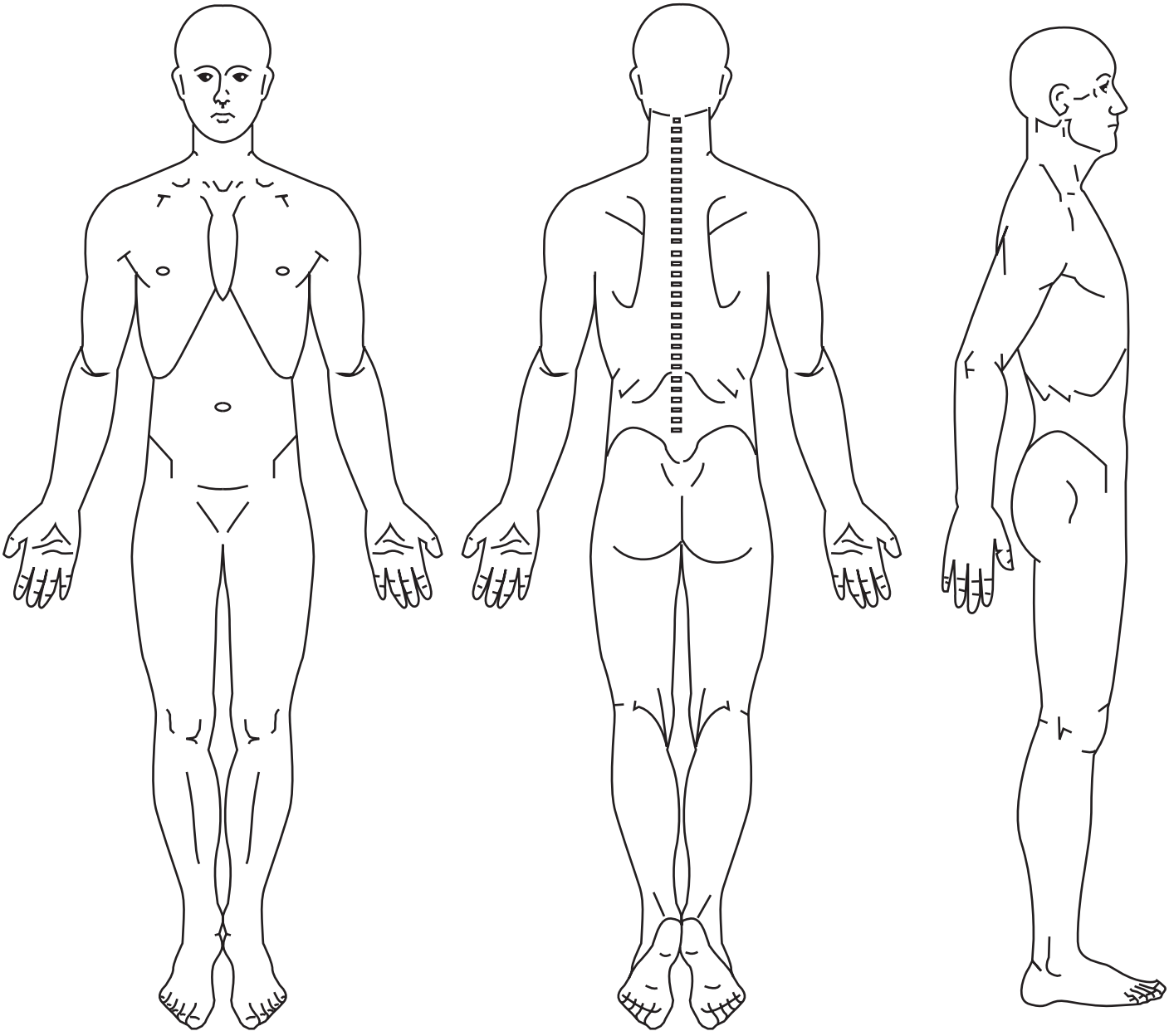
Please Print

Body Diagram Date _____ Acct# _____

Last Name _____ First Name _____

Please mark the diagrams according to where you experience your symptoms and pain using the following symbols:

X for Sharp Pain ***O*** Dull Ache /// Burning Pain *** Numbness



Patient's Signature _____ Date _____