AUTOMOBILE ACCIDENT HISTORY FORM

Last Name_____ First Name _____

Address: _____City:_____ Zip:_____
Email:_____
Home Phone:_____ Work Phone:_____Cell Phone: _____
Date of Birth: Driver's License No: So. Sec.#

Date of injury: _____Time of injury:_____ ☐ AM ☐ PM

City where crash occurred:
Street (location) where crash occurred:
What is the estimated damage to your vehicle?
Who made damage estimates on your vehicle?
Who owns the vehicle you were involved in:
☐ Yes ☐ No Did the police come to the accident scene and make a report?
☐ Yes ☐No Were you cited by the police? If yes, name of officer:

DESCRIBE HOW THE CRASH HAPPENED:_____

_____

_____

_____

_____

COLLISION DESCRIPTION: Check all that apply to you. Were you involved in the following type of accident?

☐ Single-car crash	☐ Two-vehicle crash	☐ Three or more vehicles
☐ Rear-end crash	☐ Side crash	☐ Rollover
☐ Head-on crash	☐ Hit guardrail/tree	☐ Ran off road

INDICATE YOUR SEATING POSITION

☐ Driver	☐ Front passenger	☐ Rear passenger

DESCRIBE THE VEHICLE YOU WERE IN:

Model Year and Make:

☐ Small car	☐ Mid-sized car	☐ Full-sized car
☐ Pick-up truck/sports utility	☐ Large truck	☐ Large bus or semi-truck

DESCRIBE THE OTHER VEHICLE:

Model year and Make:

☐ Small car	☐ Mid-sized car	☐ Full-sized car
☐ Pick-up truck/sports utility	☐ Large truck	☐ Large bus or semi-truck

ESTIMATED CRASH SPEEDS

Estimate how fast your vehicle was moving at time of crash. _____ mph ☐ Unknown
Estimate how fast the other vehicle was moving at time of crash. _____ mph ☐ Unknown

Signature _____ Date:_____/_____/_____

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AT THE TIME OF IMPACT YOUR VEHICLE WAS:

☐ Slowing down	☐ Gaining speed
☐ Stopped; was the driver's foot on the brake? Yes	☐ Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐ Slowing down	☐ Gaining Speed
☐ Stopped	☐ Moving at steady speed

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, hitting car in front	☐	Spun around, hitting another car
☐	Was hit by another vehicle	☐	Spun around, hitting object other than car

OCCUPANT DESCRIPTIONS: Check all areas that apply to you.

☐	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
☐	You were aware of the impending crash and relaxed before the collision
☐	You were aware of the impending crash and braced yourself
☐	Your body, torso, and head were facing straight ahead
☐	You had your head and/or torso turned at the time of collision: ☐ Turned to left ☐ Turned to right
☐	You were leaning forward at the time of impact resulting in a gap between your body and the seatback
☐	Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting- No, I always sit with a bit of a gap.

YES	NO	
☐	☐	Were you intoxicated (alcohol) at the time of crash?
☐	☐	Were you wearing a seatbelt? If yes, does your seatbelt have a shoulder harness?
☐	☐	Were you holding onto the steering wheel at the time of impact?
☐	☐	If you were involved in a rear-end crash, did your car separate away from the striking vehicle after the crash? If yes, you are indicating that after the crash your car was pushed away from the striking vehicle and your vehicle did not stay attached.

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines and match the left side to the right side.

Head	Windshield
Face	Side window
Rt/Lt Shoulder	Side door
Rt/Lt Arm/hand	Dashboard
Front/Side chest wall	Knee bolster/glove compartment
Abdomen	Seatbelt
Rt/Lt Hip	Frame of car near windows
Rt/Lt Knee	Roof of vehicle
Rt/Lt Leg/foot	Another occupant/animal
Other	Other

Signature _____ Date:_____/_____/_____

AUTOMOBILE ACCIDENT HISTORY FORM

Last Name_____ First Name _____

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR

☐ Windshield	☐ Seat frame	☐ Knee bolster
☐ Steering wheel	☐ Side-rear window	☐ Rear Bumper
☐ Dash	☐ Mirror	☐ Other

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Does your vehicle have:

- ☐ Movable/adjustable head restraint
- ☐ Fixed, non-moveable head restraint
- ☐ No headrests in my vehicle

Please indicate how your <u>head restraint</u> was positioned at the time of crash.*

- ☐ At the top of the back of your head
- ☐ Midway height of the back of your head
- ☐ Lower height of the back of your head
- ☐ Located at the level of your neck
- ☐ Located at the level of your shoulder blades (upper back) below neck

* Estimate the distance between the back of your head and the front of the headrest._____

Did your body (chest, face, head) hit the roof of your vehicle? ___ Hit the steering wheel? ___ Dash? ___
Other structures within your vehicle? ___ If yes, indicate what happened: _____

Did your car separate away from the striking vehicle after the crash?___ If yes, you are indicating that after the crash your car was pushed away from the striking vehicle and your vehicle did not stay attached. If yes, indicate your estimate of the distance between vehicles after the crash: ____feet.

ALL TYPES OF COLLISIONS

Answer this section regardless of the type of crash; indicating those relevant to your case.

YES	NO	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Did your body slide under the seatbelt?
☐	☐	Was the door(s) of your vehicle damaged to point where you could not open the door?
☐	☐	Have you noticed any visible bruising on your body since the accident? Where:_____
☐	☐	Did you lose consciousness (black out) upon impact? How long:_____
☐	☐	Did you become **CONFUSED** **DISORIENTED** **LIGHT HEADED** **DIZZY** **NAUSEATED** **BLURRED VISION** **RING/BUZZ IN EARS** From the Accident? (if yes, please circle)
☐	☐	Do you still have any of the above symptoms? _____ Which ones:

Signature _____ Date:_____/_____/_____

AUTOMOBILE ACCIDENT HISTORY FORM

Last Name_____ First Name _____

WHAT HAPPENED RIGHT AFTER THE ACCIDENT?

YES	NO	
☐	☐	Did you go to the emergency room afterward? _____ Date:_____ Time:_____ Name of the emergency room? City:
☐	☐	Did you go to emergency room in an ambulance? Name of ambulance:
☐	☐	Did you or another person drive you to emergency room? Name of other person:
☐	☐	Were you hospitalized after being seen in the Emergency Room? How many days:
☐	☐	Did the emergency room doctor take X-rays? Check what regions x-rays were taken: ☐ Skull/Face x-rays ☐ Ribs/Chest X Neck or Middle back x-rays ☐ Collar bone X Low back or Hip/Pelvis x-rays ☐ Shoulder, Arm or Hand ☐ Leg or Foot ☐ Other
☐	☐	Did the hospital or clinic take MRI or CT of your body? If yes, indicate where taken: ☐ Skull, ☐ Neck, ☐ Low back or hip/pelvis, ☐ Other
☐	☐	Did you have any broken bones/fractures? Where:
☐	☐	Did you have a cast put on for the fracture? Type/location:
☐	☐	Did you have any dislocations? Where:
☐	☐	Did you have any cuts or lacerations? Where:
☐	☐	Did you have any skin abrasions? Where:
☐	☐	Did you require any stitching for cuts? Where:
☐	☐	Did you have any visible bruises or lumps? Where:
☐	☐	Did you have any visible bruises along the shoulder or lap portions of your seatbelt?
☐	☐	Did the emergency room doctor give you pain medications?
☐	☐	Did the emergency room doctor give you muscle relaxants?
☐	☐	Did the emergency room doctor give you any other medications/prescriptions?
☐	☐	Were you told you had a herniated or bulging disc in your neck or back? Where:
☐	☐	Were you given a neck collar or back brace to wear?
☐	☐	Did you require any surgery after the accident? Describe type and date:
☐	☐	Were you hospitalized overnight? Indicate dates hospitalized:

HOW SOON DID YOU FIRST NOTICE ANY PAIN-SORENESS AFTER YOUR INJURY?

☐	Immediately (less than 30 min)	☐	_____ Hours after injury	☐	_____ Days after injury

IF YOU <u>DID NOT</u> SEE A DOCTOR FOR THE FIRST TIME WITHIN THE TWO WEEKS, INDICATE WHY: (Check all that apply only if you had delay in seeing doctor)

☐	No pain was noticed	☐	No appointment schedule available	☐	Thought pain would go away
☐	No transportation	☐	Work/home schedule conflicts	☐	Other:

HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?

☐ YES ☐ NO If yes, you were off work: ☐ Partially ☐ Completely
Please list all dates off work: From _____ to _____.

- If you had neck and/or back pain so severe that you were unable to get out of bed, how many hours after the accident did you develop this disabling level of pain? _____hours.

Signature _____ Date:_____/_____/_____

SYMPTOM SURVEY

HOW DID YOU FEEL ***BEFORE*** THE ACCIDENT? **PART 1 of 4**

HEAD

- ❑ Sinus (Allergy)
- ❑ Entire Head
- ❑ Back of Head
- ❑ Forehead
- ❑ Temples
- ❑ Migraine
- ❑ Head feels heavy
- ❑ Loss of memory
- ❑ Light-Headiness
- ❑ Fainting
- ❑ Light bother eyes
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Loss of taste
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Loss of hearing
- ❑ Pain in ears
- ❑ Ringing in ears
- ❑ Buzzing in ear

NECK

- ❑ Pain in Neck
- ❑ Neck feels out of place
- ❑ Muscles spasms in neck
- ❑ Grinding sounds in neck
- ❑ Popping sounds in neck
- ❑ Arthritis in neck
- ❑ Neck pain with movement
  - o Forward
  - o Backward
  - o Turn to left
  - o Turn to right
  - o Bend to left
  - o Bend to right

ARMS AND HANDS

- ❑ Pain in upper arm R L
- ❑ Pain in elbow R L
- ❑ Movement irritates R L
- ❑ Tennis elbow R L
- ❑ Pain in forearm R L
- ❑ Pain in hands R L
- ❑ Pain in fingers R L
- ❑ Sensation of pins and need in arms R L
- ❑ Sensation of pins and needles in fingers R L
- ❑ Numbness in arms R L
- ❑ Fingers go to sleep R L
- ❑ Hands cold R L
- ❑ Swollen joints in fingers R L
- ❑ Sore joints in fingers R L
- ❑ Arthritis in fingers R L
- ❑ Loss of grip strength R L

SHOULDERS

- ❑ Pain in shoulder joint
  - o Right
  - o Left
- ❑ Bursitis
  - o Right
  - o Left
- ❑ Arthritis
  - o Right
  - o Left
- ❑ Can't raise arm
  - o Above shoulder level
  - o Over head
- ❑ Tension in shoulders
- ❑ Muscle spasms in shoulders
- ❑ Pain across shoulders

MID BACK

- ❑ Mid-back pain
- ❑ Location _____
- ❑ Pain between shoulder blades
- ❑ Sharp stabbing
- ❑ Dull ache
- ❑ Pain from front to back
- ❑ Muscle spasms
- ❑ Pain in kidney area

LOW BACK

- ❑ Low Back Pain
- ❑ Upper lumbar
- ❑ Lower lumbar
- ❑ Sacroiliac
- ❑ Low back pain is when:
  - o Working
  - o Lifting
  - o Stooping
  - o Standing
  - o Sitting
  - o Bending
  - o Coughing
  - o Lying down (sleeping)
  - o Walking
- ❑ Pain relieved when: _____
- ❑ Slipped diskLow back feels out of place
- ❑ Muscle spasms
- ❑ Arthritis

Signature _____ Date:_____/_____/_____

HOW DID YOU FEEL ***BEFORE*** THE ACCIDENT? **PART 2 of 4**

CHEST

- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Pain around ribs
- ❑ Breast pain
- ❑ Dimpled or Orange peel breast
- ❑ Irregular heartbeat

ABDOMEN

- ❑ Nervous stomach
- ❑ Nausea
- ❑ Hemorrhoids
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas

HIP, LEGS, AND FEET

- ❑ Pain in buttocks R L
- ❑ Pain in hip joint R L
- ❑ Pain down leg R L
- ❑ Knee pain R L
  - o Inside
  - o Outside
- ❑ Leg cramps R L
- ❑ Cramps in feet R L
- ❑ Pins and needles in legs R L
- ❑ Numbness of leg R L
- ❑ Numbness of toes R L
- ❑ Feet feel cold R L
- ❑ Swollen ankles R L
- ❑ Swollen feet R L

WOMEN

- ❑ Menstrual pain
  - o Location _____
- ❑ Cramping
- ❑ Irregularity
- ❑ Cycle _____ days
- ❑ Birth control _____ (type)
- ❑ Hysterectomy
- ❑ Genital cancer _____
- ❑ Discharge
- ❑ Menopause
- ❑ Tumors
- ❑ Abortions
- ❑ Are you or do you think you are pregnant? _____

MEN

- ❑ Urinary frequency _____
- ❑ Difficulty in starting
- ❑ Night urination
- ❑ Prostate pain/ swelling

GENERAL

- ❑ Nervousness
- ❑ Irritable
- ❑ Depressed
- ❑ Fatigue
- ❑ Generally feel run-down
- ❑ Normal sleep _____hrs/night
- ❑ Loss of sleep _____hrs/ night
- ❑ Loss of weight _____lbs.
- ❑ Gain weight _____ lbs.
- ❑ Coffee _____ cups/day
- ❑ Tea_____ cups/day
- ❑ Cigarettes _____ pack/day
- ❑ Diabetes
- ❑ Hypoglycemia

Remarks:_____
_____

Signature _____ Date:_____/_____/_____

SYMPTOM SURVEY

HOW DID YOU FEEL ***AFTER*** THE ACCIDENT? PART 3 of 4

HEAD

- ❑ Sinus (Allergy)
- ❑ Entire Head
- ❑ Back of Head
- ❑ Forehead
- ❑ Temples
- ❑ Migraine
- ❑ Head feels heavy
- ❑ Loss of memory
- ❑ Light-Headiness
- ❑ Fainting
- ❑ Light bother eyes
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
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- ❑ Ringing in ears
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ARMS AND HANDS

- ❑ Pain in upper arm
- ❑ Pain in elbow
- ❑ Movement aggravated
- ❑ Tennis elbow
- ❑ Pain in forearm
- ❑ Pain in hands
- ❑ Pain in fingers
- ❑ Sensation of pins and needles in arms
- ❑ Sensation of pins and needles in fingers
- ❑ Numbness in arms (R-L)
- ❑ Fingers go to sleep
- ❑ Hands cold
- ❑ Swollen joints in fingers
- ❑ Sore joints in fingers
- ❑ Arthritis in fingers
- ❑ Loss of grip strength

SHOULDERS

- ❑ Pain in shoulder joint
  - o Right
  - o Left
- ❑ Bursitis
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  - o Left
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  - o Left
- ❑ Can't raise arm
  - o Above shoulder level
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MID BACK

- ❑ Mid-back pain
- ❑ Location _____
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- ❑ Lower lumbar
- ❑ Sacroiliac
- ❑ Low back pain is when:
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  - o Lifting
  - o Stooping
  - o Standing
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  - o Bending
  - o Coughing
  - o Lying down (sleeping)
  - o Walking
- ❑ Pain relieved when: _____
- ❑ Slipped disk - Low back feels out of place
- ❑ Muscle spasms
- ❑ Arthritis

Signature _____ Date:_____/_____/_____

HOW DID YOU FEEL ***AFTER*** THE ACCIDENT? **PART 4 of 4**

CHEST

- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Pain around ribs
- ❑ Breast pain
- ❑ Dimpled or Orange peel breast
- ❑ Irregular heartbeat

ABDOMEN

- ❑ Nervous stomach
- ❑ Nausea
- ❑ Hemorrhoids
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas

HIP, LEGS, AND FEET

- ❑ Pain in buttocks
- ❑ Pain in hip joint
- ❑ Pain down leg
- ❑ Knee pain
  - o Inside
  - o Outside
- ❑ Leg cramps
- ❑ Cramps in feet
- ❑ Pins and needles in legs
- ❑ Numbness of leg
- ❑ Numbness of toes
- ❑ Feet feel cold
- ❑ Swollen ankles
- ❑ Swollen feet

WOMEN

- ❑ Menstrual pain
  - o Location _____
- ❑ Cramping
- ❑ Irregularity
- ❑ Cycle _____ days
- ❑ Birth control _____ (type)
- ❑ Hysterectomy
- ❑ Genital cancer _____
- ❑ Discharge
- ❑ Menopause
- ❑ Tumors
- ❑ Abortions
- ❑ Are you or do you think you are pregnant? _____

MEN

- ❑ Urinary frequency _____
- ❑ Difficulty in starting
- ❑ Night urination
- ❑ Prostate pain/ swelling

GENERAL

- ❑ Nervousness
- ❑ Irritable
- ❑ Depressed
- ❑ Fatigue
- ❑ Generally feel run-down
- ❑ Normal sleep _____hrs/night
- ❑ Loss of sleep _____hrs/ night
- ❑ Loss of weight _____lbs.
- ❑ Gain weight _____ lbs.
- ❑ Coffee _____ cups/day
- ❑ Tea_____ cups/day
- ❑ Cigarettes _____ pack/day
- ❑ Diabetes
- ❑ Hypoglycemia

Remarks:_____
_____

Signature _____ Date:_____/_____/_____

Kowalik Family Chiropractic

NEW PATIENT CHECK LIST FOR PERSONAL INJURY CASE

To best process your personal injury case, please bring with you the following with you to your appointment. If you need assistance or have any questions, please contact our office at 949-380-8883 and we will be happy to assist.

YOUR INSURANCE INFORMATION:

____ COPY OF AUTO INSURANCE CARD

____ CLAIM #

____ ADJUSTER'S NAME_____ PHONE #_____

____ AUTO INSURANCE POLICY MEDICAL PAYMENT COVERAGE (Medpay) $_____

____ MEDICAL INSURANCE INFORMATION & COPY OF INSURANCE CARD

RESPONSIBLE PARTY'S INSURANCE INFORMATION:

____ ACCIDENT REPORT or RECEIPT OF REPORT WHICH WAS FILED

IF AN ACCIDENT REPORT WAS NOT TAKEN, PLEASE PROVIDE THE FOLLOWING:

____ RESPONSIBLE PARTY'S NAME, ADDRESS, PHONE NUMBER & INSURANCE INFORMATION (see accident report if a report was completed)

____ COPY OF OTHER DRIVER'S AUTO'S INSURANCE INFORMATION WITH CLAIM NUMBER AND ADJUSTER'S NAME

ADDITIONAL ITEMS IF APPLICABLE

____ PHOTOS OF VEHICLE

____ EMERGENCY ROOM &/ OR AMBULANCE REPORT

ATTORNEY INFORMATION

____ IF YOUR HAVE AN ATTORNEY, PLEASE PROVIDE:

ATTORNEY'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

Signature _____ Date:_____/_____/_____