Patient's Name: **Today's Date**:

MOTOR VEHICLE COLLISION HISTORY

Please read and sign Motor Vehicle Injury Policy for Catherine Englehart, DC, PS

Date of Collision:_____ Time of Collision:_____ AM/PM

Type of Vehicle you were in: Year:_____ Make:_____ Model:_____

_____

Were you the: Driver / Front Passenger / Right Rear Passenger / Left Rear Passenger / Other*

*If Other, please describe:_____

Location of collision (including Street, City & Other information you can provide):_____

_____

_____

What was your car doing at time of collision? (i.e.: stopped waiting to turn?): _____

_____

_____

How was your car hit? (ex: side, front): _____

Amount of damage to your car: TOTALED MODERATE MINIMAL UNKNOWN

At-fault person's name: _____

At-fault person's address: _____

Second vehicle involved: Year:_____ Make:_____ Model:_____

Amount of damage to other car: TOTALED MODERATE MINIMAL UNKNOWN

Describe the weather at time of impact:_____ Visibility?: GOOD FAIR POOR

Describe the road conditions: DRY WET ICY OTHER _____

_____

What were your body & head positions at time of impact? (ex: body turned right with my head left):

_____

_____

Direction your body was thrown? (ex: forward, side to side): _____

_____

Were you wearing a seatbelt?: YES NO If YES, was it a: SHOULDER BELT / LAP BELT /BOTH

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Did the vehicle airbags deploy (if equipped): YES NO Did you lose consciousness: YES NO

Did you experience a flash of light or explosion: YES NO Did you brace for impact: YES NO

Did the police come to the scene: YES NO

Is there a police report on file: YES NO (If YES, please provide us with a copy)

Provide a detailed description of the collision: _____

_____

_____

_____

_____

POST-COLLISION:

Your reaction to collision: SHAKEN UPSET CONFUSED DISORIENTED DIZZY NORMAL

_____

Where did you go immediately after the collision: Home / Work / ER / Urgent Care /Hospital / Other:

If you sought care, where did you go? _____

How did you get there? (ambulance, I drove, etc): _____

_____

Type of emergency care: ER BANDAGING BRACING CPR NECK COLLAR SPLINTING _

_____

Did you have any cuts or bruises? YES NO If yes, where?: _____

_____

Have you seen another healthcare provider for the injuries you received: YES NO (If YES, please list below):

Name: _____ Specialty: _____ Date(s): _____

_____

Name: _____ Specialty: _____ Date(s): _____

_____

TREATMENT POST-COLLISION:

Were you admitted to the hospital?: YES NO Which one?: _____

Did you receive: X-RAYS CAT SCAN MRI OTHER: _____

What parts were tested: (arm, head, lower back, neck) _____

_____

Were you prescribed any medication(s)? YES NO If YES, please list below:

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Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Doctor's recommendations: _____

_____

Have you had treatment to these areas prior to the collision? YES NO If YES, please describe:

_____

_____

SOCIAL HISTORY:

Dominant Hand: Right / Left / Ambidextrous Current Height: _____ Weight: ____

_____

Do you exercise? YES NO Types: _____ Frequency: _____

Weight prior to the collision: _____ Do you think you're overweight? YES NO If YES, how much: _____

Current employer: _____ Hours per week: _____

Current occupation: _____ Yearly income: _____

_____

Type of Work: Light / Heavy / Mental / Physical Education Level: _____ Degree Earned:

_____

Have you smoked cigarettes in the past 12 mos?: Yes No Amount & Frequency: _____ # of Years:

Hours of Sleep per Night: _ Number of Children: _____ Number of those who live with you:

_____

Do you travel internationally? YES NO Frequency: _____

Did you serve in the military? YES NO If YES, did you suffer from war trauma? YES NO

Describe: _____ Were you discharged? Type:

_____

Any Physical or Mental Handicaps? Describe:_____

PRESENT SYMPTOMS LIST:

Head: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____

_____

Was this here prior to collision? YES NO

Neck: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____

_____

Was this here prior to collision? YES NO

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Chest: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Was this here prior to collision? YES NO

Shoulder: Pain Scale:(mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Upper Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Back: Was this here prior to collision? YES NO

Mid Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Back: Was this here prior to collision? YES NO

Arm: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Hand: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Lower Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Back: Was this here prior to collision? YES NO

Buttocks: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Hip/ Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Thigh: Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Knee: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

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Calf: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Shin/ Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Ankle: Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Foot: Pain Scale: (mild) 0 1 2 3 4 5 6 7 8 9 10 (worst) Frequency: _____ _____

Was this here prior to collision? YES NO Please circle which side: LEFT RIGHT BOTH

Other: _____

_____

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On the pictures below, use the indicated marks to show areas where you are experiencing: Pain = XXX Numbness = /// Tingling = +++