

MEEKER CHIROPRACTIC

4229 Northern Pike
Monroeville, PA 15146

Auto-Accident Form

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient Yes No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Auto-Accident Specific Information:

Were you the: Driver Passenger Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Damage Amount Estimate: \$ _____ : Minor Major Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender
 Minor Major Totaled

Where did the accident happen? Street Names: _____ City/State _____

Was it? Controlled Intersection Uncontrolled Not Intersection

Was there a traffic light? None Green Red Turn Arrow Stop Sign

Were you: Slowly Moving Moving Stopped

Weather Conditions: Sunny Rainy Cloudy

Street Surface: Dry Wet Slick Icy Pavement Other _____

Type of Impact: Rear end Front Side Impact Roll Over

Brakes on Impact: Locked Tight Loosely Applied Foot not on brake

How far did your car move? Did not move Moved 1-5 ft Moved 6-10 ft Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? Yes No

Shoulder harness: Yes No Headrest: Yes No Headrest Position: Up Down
 Is the car equipped with airbags? Yes No Did they deploy? Yes No
 Did you see the impact coming? Yes No Did you brace yourself for impact? Yes No
 On impact, your head was looking: Ahead Behind Up Down To the Right To the Left
 On impact were you: Thrown forward Thrown backwards Thrown sideways Other _____
 Did your body hit anything inside the car? Yes No Body Part: _____
 What did it hit? _____
 Head trauma? Yes No Loss of Consciousness? Yes No For how long? _____
 Do you remember the accident happening? Yes No
 Hospital? Yes No Name of hospital: _____ How long there? _____
 Taken by ambulance? Yes No
 X-rays taken? Yes No X-ray areas: Neck Mid-back Low-back Other X-rays _____
 Medication Given? Yes No RX: _____
 Other instruction: _____ Follow-up: _____

Additional Information Related to the Condition:

Describe your pain: Burning Sharp Dull Ache
 What caused it? _____
 What aggravates it? _____
 What relieves it? _____
 Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No
 When? ___/___/___
 Describe: _____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

- Headache
 - Loss of Memory
 - Hands Cold
 - Numbness in arms/hands
 - Cold Sweats
 - Irritability
 - Loss of strength - arms
 - Dizziness
 - Clumsiness
 - Sleeping Problems
 - Buzzing in Ears
 - Tension
 - Loss of Smell
 - Burning muscle pain
 - Light Bothers Eyes
 - Feet Cold
 - Tingling in legs/feet
 - Constipation
 - Shortness of Breath
 - Chest pain/rib pain
 - Loss of strength - legs
 - Diarrhea
 - Neck Stiff
 - Face Flushed
 - Nervousness
 - Fainting
 - Pain in arms/hands
 - Difficulty swallowing
 - Head seems too heavy
 - Tingling in arms/hands
 - Nausea
 - Numbness in legs/feet
 - Fever
 - Pain in legs/feet
 - Sharp/shooting pain
 - Neck Pain
 - Ears Ring
 - Back Pain
 - Loss of Balance
 - Fatigue
 - Jaw pain
- Other _____

Have you experienced changes to:

- Eyes (sight) Ears (hearing) Nose (smell) Mouth (taste) Bladder
 Bowels Sleep Emotion Appetite

Please Explain: _____

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Notes: _____

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

- 1) _____ / /
- 2) _____ / /
- 3) _____ / /

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

- Heart Disease Diabetes Cancer Stroke High Blood Pressure Thyroid Problems
 Tuberculosis Prostate Disorder Kidney Problems Asthma Ulcer Seizure Disorder

Other: _____