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CAROLINA® CHIROPRACTIC

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Patient Name_____

(PLEASE CHECK or CIRCLE ALL THAT APPLY)

►**Were you hit: from behind, head-on, side-swiped, or struck another vehicle?**

►**Describe what happened** (ie: front, side, rear impacts)_____

_____

►**Date of current AUTO accident?**_____

►**Any previous Auto accidents?** Yes No
If YES, when?_____Did you receive treatment for that injury? Yes No

►**In the most recent Auto accident, were you the:**
☐ Driver ☐ Passenger ☐ Pedestrian ☐ On bike

►**Please locate your position at the time of the accident:**
☐ Front Seat ☐ Rear seat, passenger side ☐ Rear seat, driver side

►**Were you:**
☐ Stopped and Struck From Behind
☐ Moving and Struck From Behind
☐ Stopped and Struck in Front-End
☐ Moving and Struck in Front-End
☐ Hit From Right Side
☐ Hit From Left Side
☐ Side Swiped
☐ Did more than one impact occur?

►**Were you wearing a seat belt?** Yes No

►**Upon impact, which way was your head turned?**
☐ Left ☐ Right ☐ Ahead

►**Upon impact, did any portion of your body strike any objects in the car?** Yes No

If YES, what portion of your body did you strike? (Please circle L for left and R for right)
L R Head -- L R Knees -- L R Arms -- L R Hands -- L R Shoulders -- L R Other_____

►**What objects did you strike?**
☐ Steering Wheel
☐ Side Window Left Right (circle)
☐ Side Door Left Right (circle)
☐ Center Console
☐ Can't Remember
☐ Other
☐ Dash Board
☐ Rear View Mirror
☐ Windshield
☐ Headrest
☐ _____
☐ _____

CHECK and Circle ALL THAT APPLY
- ○ Any recent fever, weight loss/gain
- ○ Skin problems, cysts
- ○ Breathing, lung, allergies
- ○ Digestive, appetite, heartburn, constipation, diarrhea
- ○ Circulation, heart, stroke, fainting
- ○ Mood, depression, anxiety, sleep disturbance, nervous
- ○ Hormonal/Reproductive, urinary
- ○ Head, ear, nose, eyes, dizziness, vertigo, sinus
- ○ Any loss of control bowel/bladder
- ○ None Apply

Check symptoms you have noticed since accident. **PATIENT NAME**_____

Head & Neck

- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck Spasms
- ☐ Headaches
- ☐ Arm Pain
- ☐ Pins/Needles in Arms
- ☐ Numbness in Fingers
- ☐ Hands Cold
- ☐ Eyes Sensitive to Light
- ☐ Dizziness
- ☐ Head Seems too Heavy
- ☐ Grinding Sensations in Neck
- ☐ Loss of Balance
- ☐ Loss of Memory
- ☐ Nervousness
- ☐ Fatigue
- ☐ Sleeping Problems
- ☐ Fainting Spells
- ☐ Any Other Pain or Sensations? _____

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst) ☐

Mid-Back

- ☐ Mid Back Pain
- ☐ Mid Back Stiffness
- ☐ Mid Back Spasms
- ☐ Pain in Ribs/Side
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Breathing, Coughing, Sneezing Results in Increase of Pain
- ☐ Any Other Pain or Sensations? _____

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst) ☐

Low Back

- ☐ Low Back Pain
- ☐ Low Back Stiffness
- ☐ Low Back Spasms
- ☐ Leg/Hip Pain
- ☐ Pins/Needles in Legs
- ☐ Numbness in Toes
- ☐ Feet Cold
- ☐ Breathing, Coughing, Sneezing Results in Increase of Pain
- ☐ Any Other Pain or Sensations? _____

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst) ☐

PATIENT NAME _____

►**Were you?**

☐ Dazed ☐ Unconscious ☐ Cut (Where?)

☐ Bruised, where? ☐ _____

☐ Cuts/scrapes, where? ☐ _____

☐ Other Injuries not Listed Above? ☐ _____

►**Did you have:**

☐ Momentary Deafness ☐ Loss of Balance ☐ Nausea

☐ Ringing in Ears ☐ Blurred Vision ☐ Dizziness

☐ Immediate Pain ☐ Gradual Pain ☐

►**Were the symptoms present before the accident?** Yes No

►**If Yes, please describe** _____

_____

►**What Hospital?**

☐ WakeMed / WakeMed North, West ☐ Rex ☐ Duke Health Raleigh ☐ Other _____

►**If you were taken to the Emergency Room immediately, How?**

☐ Ambulance ☐ Drove Yourself ☐ Taken by Someone ☐ Other _____

►**If you went home and later went to the Emergency Room or other Doctor?**

Date ☐ ☐ Hospital ☐ Doctor _____

►**Were you seen in the Emergency Room?** Yes No

►**Were you admitted to the Hospital?** Yes No

►**What procedure were done in the Emergency Room/Hospital?**

☐ Examination ☐ Stitches ☐ X-Rays ☐ Neck Collar ☐ Brace ☐ Shot

☐ Pain Pills ☐ Muscle Relaxers ☐ Anti-Inflammatory ☐ Other _____

►**Are you taking any <u>other</u> medications currently, if yes, please list?** Yes No

If YES, please list _____

►**Have you seen any <u>other</u> Physicians for this problem?** Yes No

If YES, please name

►**Are you pregnant?** Yes No

►**Patient's Signature:** _____ ►**Date:** _____

►**Additional Notes:** Any missed work? How long? _____

What kind of work? _____

Primary Care Physician: _____

_____

_____