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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
☐ Dash Board
☐ Rear View Mirror
☐ Windshield
☐ Headrest
☐ Other

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

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** _____

_____

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

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

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

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

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

►**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 _____

►**Did you go home and later go to: the Emergency Room or other Doctor?**

Date ☐ Doctor Name: _____

►**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? No/Yes** Name:_____

►**Are you pregnant?** Yes No

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

►**Additional Notes:** <u>Any missed work? How long?</u> _____

<u>What kind of work?</u> _____

Primary Care Physician: _____

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
- ☐ Any Other Pain or Sensations? _____
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Breathing, Coughing, Sneezing Results in Increase of Pain

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
- ☐ Any other Pain or Sensations? _____
- ☐ Numbness in Toes
- ☐ Feet Cold
- ☐ Breathing, Coughing, Sneezing Results in Increase of Pain

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