Graybar Chiropractic & Rehab Centers

Motor Vehicle Accident Patient History

Patient Name _____
Today's Date ____/_____/_____ Date of Accident ____/_____/_____

Please mark your involvement in the Auto Accident: ☐ Pedestrian ☐ Driver ☐ Passenger

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Patient was located: ☐ Driver ☐ Passenger- middle front ☐ Passenger- right front
☐ Passenger- left rear ☐ Passenger- middle rear ☐ Passenger -right rear

Patient Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Second Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Third Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Road Conditions: ☐ Clear ☐ Dark ☐ Dry ☐ Foggy ☐ Icy ☐ Wet
Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐ Gravel
Weather Conditions: ☐ Clear ☐ Dark ☐ Rainy ☐ Foggy ☐ Icy

Were you aware the accident was going to occur? ☐ Yes ☐ No
Were you wearing a seatbelt? ☐ Yes ☐ No
Did your airbag deploy? ☐ Yes ☐ No

Does your car have a head rest? ☐ Yes ☐ No
What position was the head rest in? ☐ Up ☐ Middle ☐ Down

Patient's Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Accident Details

Was your car braking? ☐ Yes ☐ No **Was your car moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the second vehicle braking? ☐ Yes ☐ No **Was the second vehicle moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the third vehicle braking? ☐ Yes ☐ No **Was the third vehicle moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Collision Details

First Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left
☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top

Second Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left
☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top

Collision Results

Body was thrown: ☐ **Forward** ☐ **Backward** ☐ **Left** ☐ **Right** ☐ **Can't Remember**

Head Hit: ☐ **airbag** ☐ **front windshield** ☐ **rearview mirror** ☐ **steering wheel**
☐ **dashboard** ☐ **back of the front seat** ☐ **side window/door** ☐ **another person's body** ☐ **headrest**

Chest Hit: ☐ **airbag** ☐ **steering wheel** ☐ **dashboard** ☐ **back of the front seat**
☐ **side window/door** ☐ **another person's body**

Shoulders Hit: ☐ **shoulder harness** ☐ **side window/door** ☐ **back of front seat** ☐ **another person's body**

Knees Hit: ☐ **steering wheel** ☐ **dashboard** ☐ **back of the front seat**
☐ **door panel** ☐ **center console** ☐ **another person's body**

Hips Hit: ☐ **steering wheel** ☐ **dashboard** ☐ **back of the front seat**
☐ **door panel** ☐ **center console** ☐ **another person's body**

Vehicle Damage

Patient Vehicle: ☐ **totaled** ☐ **significant damage** ☐ **light damage** ☐ **no damage**
Second Vehicle: ☐ **totaled** ☐ **significant damage** ☐ **light damage** ☐ **no damage**
Third Vehicle: ☐ **totaled** ☐ **significant damage** ☐ **light damage** ☐ **no damage**

Hospitalized

Did you go the hospital? ☐ **No.** ☐ **Yes – Which hospital?** _____

When were you hospitalized? ☐ **immediately** ☐ **later same day** ☐ **next day** ☐ **date** _____

How were you transported to the hospital? ☐ **ambulance** ☐ **life flight** ☐ **private transportation**

What did the hospital recommend? ☐ **no instructions** ☐ **see this clinic** ☐ **see DC**
☐ **see own doctor** ☐ **see orthopedist** ☐ **see neurologist** ☐ **prescription medication**
☐ **other:** _____

Did you have any x-rays taken? ☐ **No** ☐ **Yes** **If yes, what areas?** _____
If yes, where were they taken? _____

Other physicians

Have you seen any other physicians since the accident? ☐ **No.** ☐ **Yes – Which physician?** _____
What did the physician recommend? ☐ **no instructions** ☐ **see this clinic** ☐ **see physical therapist**
☐ **see orthopedist** ☐ **see neurosurgeon** ☐ **prescription medication** ☐ **pain medication**
☐ **other:** _____

Did you have any additional x-rays taken? ☐ **No** ☐ **Yes** **If yes, what areas?** _____
If yes, where were they taken? _____

Since the injury are the symptoms: ☐ **getting worse** ☐ **same** ☐ **some better** ☐ **come and go** ☐ **constant**
Are you presently able to work? ☐ **yes** ☐ **no** **List any days missed from work:** _____

Do you have an attorney representing you regarding this accident? **( ) yes ( ) no**
If yes, name _____ **address:** _____ **phone number:** _____

Patient Signature: _____ Date: _____ Witness Signature: _____ .