 Pt. # _____

ADVANCED CHIROPRACTIC NUTRITION CENTER
Thomas A. Kiska, D.C., D.A.C.B.N. & Susan L. Shepler, D.C.

Personal Injury ACCIDENT REPORT

Your Social Security# _____ **Today's Date** _____

Patient Name: _____ Sex: M F Date of Birth: _____ Age _____
Address: _____# ___ City/State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext._____ Cell Phone/Pager: _____
Employer: _____ Avg. hours worked per week: _____ Occupation: _____
Marital Status: S M D W Sep E-mail:_____
Children's Names and Ages(if applicable): _____
Emergency Contact: _____ Phone: _____
How did you here about our office? _____
Have you been treated by a Chiropractor before? ☐ No ☐ Yes Dr.'s Name:_____
THE ACCIDENT: Date of Accident _____ Time of Day _____ a.m. / p.m. (Circle)
Location of Accident: _____
Describe the accident in your own words: _____
_____

Current Symptoms/Injuries:
Please check if you have had any of the following symptoms since your injury:

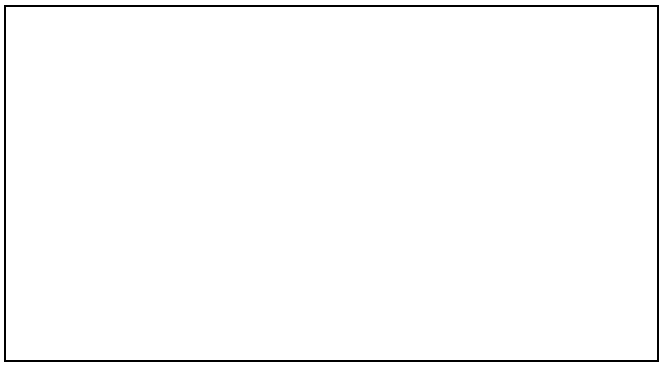
__ Arm pain	__ Hand/finger numbness	__ Neck pain	__ Head feels heavy
__ Back pain	__ Feet/toe numbness	__ Neck stiff	__ Depression
__ Back stiffness	__ Headaches	__ Shortness of breath	__ Loss of balance
__ Chest pain	__ Irritability	__ Sleep difficulty	__ Diarrhea/Constipation
__ Dizziness	__ Jaw problems	__ Stomach upset	__ Fever
__ Ear buzzing	__ Leg pain	__ Tension	__ Light bothers eyes
__ Ear ringing	__ Memory loss	__ Vision blurred	__ Pins & Needles Legs
__ Fatigue	__ Nausea/Upset Stomach	__ Nervousness	__ Pins & Needles Arms

Since the injury occurred, are your symptoms: ☐ improving ☐ getting worse ☐ same ☐ varies w/activity

- Rate the severity of your pain – from **1** (least) to **10** (severe pain): (Circle one) 1 2 3 4 5 6 7 8 9 10
- Type of pain: __ Sharp __ Dull __ Throbbing __ Numbness
  __ Aching __ Shooting __ Burning __ Tingling
  __ Cramps __ Stiffness __ Swelling __ Other _____
- Is it constant? ☐ No ☐ Yes Does it come and go? ☐ No ☐ Yes How often? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation Other: _____
Activities/movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down
Other: _____

Mark an X on the picture where you have pain.



Testing:

Have you had any specialized tests? MRI CT Scan ☐ No ☐ Yes List: _____

Do you have any herniated or bulging discs? ☐ No ☐ Yes Where?: _____

Do you have any current x-rays? (within past year) ☐ No ☐ Yes Where?: _____

Home Treatment: (Circle all that apply.)

What treatment have you tried? Ice Moist Heat Dry heat/Heating Pad Massage Bedrest Medication

List all medications and how often taken: _____

___ Ibuprofen ___Tylenol __ Aspirin _____

List all nutritional supplements and amounts taken: _____

_____

Family Physician: Dr. _____ last seen when/for what? _____

Females: Any possibility of pregnancy? ☐ No ☐ Yes Date last menstrual period began: _____

Type of birth control used: Birth Control Pill Hysterectomy Tubal Ligation Husband Vasectomy Abstinance (no sex) Other: _____

HISTORY PRIOR TO THE ACCIDENT

Have you ever had a litigated claim following an accident? ☐ No ☐ Yes When? _____

Did you receive a settlement? ☐ No ☐ Yes Have you been rated with a permanent impairment? ☐ No ☐ Yes

Prior accidents/injuries:

Auto/Cycle (type of vehicle/mph): _____

_____

Slips/falls/lifting injuries: _____

_____

Workers' Comp. Injuries: _____

_____

Any loss of consciousness resulting from accident or injury? _____

_____

List any broken bones & type of injury _____

_____

List Sports activities (include school sports, even if no injuries) _____

Surgeries: (Indicate surgeries you have had and your approximate age)

__Tonsillectomy	__Eye	__Hysterectomy	__Vasectomy	__Neck	__Skin Cancer _____
__Hemorrhoid	__Heart	__D&C	__Hernia	__Back	__Other Cancer _____
__Appendix	__Stomach	__Gall Bladder	__Knee	__Tubal Ligation	__Other _____

Hospital Stays (Surgical and Otherwise): _____

_____

Lifestyle Information: (Circle all that apply)

Smoking: Do you currently smoke? No Yes Cigarettes Cigars Smokeless Tobacco Did you smoke previously? No Yes

Packs/Day ____ # Yrs Smoking ____; # Yrs Stopped:____; Times Quit____

Coffee - #Cups/Day ____; Reg. Decaf. **Tea**: #Cups/Glasses/Day ____ **Soda**: #Day____ Reg. No Caffeine Diet

Alcoholic Beverages: Current: Never Socially Weekends Daily **Type:** Beer Wine Alcohol Amt. _____

Prior: Never Socially Weekends Daily **Type:** Beer Wine Alcohol Amt. _____

Exercise: ☐ None ☐ Very Little ☐ Moderate ☐ Daily ☐ Heavy List Types: _____

_____

Hobbies: _____ Stresses: _____

Has your weight changed over the past year? ☐ No ☐ Yes ☐ Up ☐ Down How much?_____# Have you dieted? _____

ADDITIONAL ACCIDENT INFORMATION:

Accident Site: Road/Street Name: _____ City/State _____

What direction were you headed? _____Other vehicle? _____

Driving conditions: __Dry __Wet __Icy __Other _____

What speed were you traveling? _____ MPH What speed was the other vehicle traveling? _____ MPH

Vehicle: Were you in your own vehicle? ☐ No ☐ Yes Owner of vehicle: _____
Your Car: Make:_____ Model: _____ Year _____ Amt.of Damage $_____
Were you wearing a seatbelt? ☐ No ☐ Yes ☐ Lap ☐Shoulder Did it work properly? ☐ No ☐ Yes
Was the vehicle equipped with airbags? ☐ No ☐ Yes Did they inflate properly? ☐ No ☐ Yes
Did your seat have a headrest? ☐ No ☐ Yes What was position of the headrest? ☐Low ☐Mid ☐High

Other vehicle(s):
Other Car: Make _____ Model _____ Year _____ Amt.of Damage $_____
Other Car: Make _____ Model _____ Year _____ Amt.of Damage $_____

Impact: Did any part of your body strike anything in the vehicle? ☐ No ☐ Yes Describe: _____
_____
Were both of your hands on the wheel? ☐ No ☐ Yes If not, which one was on the wheel? ☐Left ☐Right
Was your foot on the brake? ☐ No ☐ Yes Which one was on the brake? ☐Left ☐Right
At the time of impact, which position was your head in? _____
Did you see the accident coming? ☐ No ☐ Yes Were you braced for impact? ☐ No ☐ Yes
When the accident occurred, were you… __At a complete stop? __Breaking? __Accelerating? Other_____
Did your car strike another vehicle? ☐ No ☐ Yes Did the vehicle strike another vehicle? ☐ No ☐ Yes
Did your vehicle impact a structure? ☐ No ☐ Yes Explain: _____
Was there more than one impact? ☐ No ☐ Yes Describe: _____
Were you struck from: __Behind __Front __Driver's side __Passenger side Other _____

Police:
Did police come to the accident site? ☐ No ☐ Yes Was a police report filed? ☐ No ☐ Yes
Do you have a copy of the accident report? ☐ No ☐ Yes Were there any witnesses? ☐ No ☐ Yes
Was a traffic violation issued? ☐ No ☐ Yes To Whom? _____

After the Accident:
When did you first notice your injuries or symptoms? _____
Did you lose consciousness after the accident? __No __Yes How long? _____
Describe how you felt immediately after the accident. _____
_____
Did you drive yourself home? __No __Yes How did you get home? _____

Treatment after this accident:
Did you go to the hospital? __No __Yes When? __Immediately after __Next Day Other _____
How did you get to the hospital? __Rescue/Ambulance __Drove Self __Private Transportation Other:_____
Name of hospital: _____ Date: _____
What treatment was received? _____ Dr. _____
Any X-rays taken? __No __Yes What area of your body? _____
Were you hospitalized overnight? __No __Yes Have you seen your family physician since the accident? _____

Other:

Did you notify **YOUR** health insurance carrier? ☐ No ☐ Yes Insurance Co. _____

Claim #: _____ Adjuster: _____ Phone: _____

Do you have secondary insurance? ☐ No ☐ Yes Insurance Co. _____

Have you been able to work since this injury? ☐ No ☐ Yes How many days have you missed? _____

Prior to the injury, were you able to work on an equal basis with others your age? ☐ No ☐ Yes

Have you had previous complaints in the injured area? ☐ No ☐ Yes

If yes, describe: _____

Have you retained an attorney? ☐ No ☐ Yes

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone Number: _____

Release of Medical Information to Insurance Carrier:

I give permission to ADVANCED CHIROPRACTIC NUTRITION CENTER to release all medical and chiropractic information including consultation, history, reports, examination and treatment in relation to my care to my insurance carrier in order to facilitate processing of my health care claims.

I certify that the above information is correct to the best of my knowledge:

Patient Signature_____ Date_____

Parent/Legal Guardian Signature_____ Date_____