



Falite Chiropractic

The Brain Balance Place



Accident Case History

Name: _____ Date: _____ Date of Accident: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: M S D W email: _____

Phone (Home): _____ (Work): _____ SS #: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Names & Ages of Children: _____

Who referred you to our office: _____ Relationship: _____

By signing below, I understand that I am ultimately responsible for the payment of the balance due for my care. Per the doctor's discretion, he/she may agree to wait for payment-in-full until my case has settled (credit card number to remain on file).

Patient's Signature: _____ Date: _____

Credit Card #: _____ EXP Date: _____ Billing Zip Code: _____

PLEASE DESCRIBE YOUR COMPLAINTS:

Involving neck and head: _____

Involving mid-back/shoulders/arms/hands: _____

Involving low back/hips/legs/feet: _____

What activities make your condition worse? _____

What activities make your condition better? _____

OVER

INDICATE THE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

U - Unable P -Painful D - Difficult L - Limited N - Normal

- | | | |
|--|---|---|
| <input type="checkbox"/> Coughing or sneezing | <input type="checkbox"/> Climbing | <input type="checkbox"/> Gripping |
| <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Pushing |
| <input type="checkbox"/> Bending forward to brush teeth | <input type="checkbox"/> Balancing | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Dressing self | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Walking short distances | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Bending forward |
| <input type="checkbox"/> Standing for more than one hour | <input type="checkbox"/> Stooping | <input type="checkbox"/> Sexual activity |
| <input type="checkbox"/> Lying on back | <input type="checkbox"/> Lying flat on stomach | <input type="checkbox"/> Sitting at a table |
| | <input type="checkbox"/> Lying on side w/knees bent | |

Check symptoms of Nervous Stress:

- | | |
|--|---|
| <input type="checkbox"/> Blurring vision | <input type="checkbox"/> Headaches (How often? _____) |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Buzzing/ringing of ears | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Muscle jerking |
| <input type="checkbox"/> Depression or crying spells | <input type="checkbox"/> Low resistance |
| | <input type="checkbox"/> Confusion |
| | <input type="checkbox"/> Convulsions |
| | <input type="checkbox"/> Paralysis |

Check proper space:

- Symptoms are BETTER in: AM Midday PM
 Symptoms are WORSE in: AM Midday PM
 Symptoms do not change with time of day

Date of last x-rays: _____

Women Only: Are you (or could you be) pregnant? Yes No

Time of accident: _____ (AM/PM) Driver of Car: _____ Where were you seated? _____

Who owns the car? _____ Year and model of car: _____

What was the approximate damage done to your car? \$ _____

Where was your car struck? right left rear front side

Type of accident: head-on collision broad-side collision
 rear-end collision front impact, rear-ended car in front
 non-collision: _____

Describe in your own words what happened to you upon impact: _____

- a) Did you see the accident coming? yes no
- b) Did you brace for impact? yes no
- c) Were seat belts worn? yes no
- d) Were shoulder harnesses worn? yes no
- e) Does your car have headrests? yes no
- f) If yes, what was the position of those headrests compared to your head before the accident?
 top of headrest even with bottom of head
 top of headrest even with top of head
 top of headrest even with middle of neck
- g) Was your car breaking? yes no
- h) Was your car moving at the time of the accident? yes no
- i) If yes, how fast would you estimate you were going? _____ m.p.h.
- j) How fast was the other car traveling? _____ m.p.h.

Head/Body position at time of impact:

- head turned left/right
- head looking back
- head straight forward
- body straight in sitting position
- body rotated left/right
- other: _____

a) At the time of impact, recall what parts of your head or body hit what parts on the inside of your car: _____

b) As a result of the accident you were:

- rendered unconscious
- dazed/circumstances vague
- Other: _____

c) Could you move all parts of you body? yes no

If no, what parts and why? _____

d) Were you able to get out of the car and walk unaided? yes no

If no, why not? _____

Did you get bleeding cuts or bruises? yes no

If yes, explain: _____

Please describe how you felt. Please be specific.

a) Immediately after the accident: _____

b) Later that day night: _____

c) The next day night: _____

Check symptoms apparent since the accident:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Tension | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Ringing/buzzing ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Other: _____ |

Occupation: _____ Employer: _____

Have you missed time from work? yes no

- If yes, full-time off work _____ to _____
- part-time off work _____ to _____
- been unable to work since accident

Did you seek medical help immediately/soon after the accident? yes no

- If yes, how did you get there?
- Someone else drove me
- Drove own car
- Ambulance
- Police

Doctor/Hospital/Clinic seen: _____ Date of first visit: _____

Were you examined? yes no Were X-rays taken? yes no

Were you given treatment? yes no

If yes, what treatment was given to you? _____

What benefits did you receive from this treatment? _____

Date of last treatment: _____

Did you have any physical complaints just before the accident? ___yes ___no

If yes, please describe in detail: _____

Prior to this accident, have you ever had symptoms similar to what you're experiencing now? ___yes ___no

If yes, please explain: _____

Do you notice any activities of your home daily routines that are different now than from before the accident?

___yes ___no

If yes, list them: (Please be specific)

a) Those you are unable to do: _____

b) Those that are painful to do: _____

c) Those that are difficult to do: _____

On a scale from 1 to 10 with "1" being pain free and can function quite well and "10" being in pain all the time and cannot function at all, rate yourself. Circle one: 1 2 3 4 5 6 7 8 9 10

Automobile Accident - Insurance Data

Attorney Information:

Do you have an attorney on this case? ___yes ___no

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Patient's Car Insurance Information:

Company Name: _____ Phone: _____ Policy# _____

PO Box/Street #: _____ Adjuster's name: _____

City/State/Zip: _____

Insured's Car Insurance Information:

Insured's name if other than patient: _____ Phone: _____

Company Name: _____ Phone: _____ Policy# _____

PO Box/Street#: _____ Adjuster's name: _____

City/State/Zip: _____

Other Driver's Car Insurance Information:

Other Driver's name (if another car was involved): _____ Phone: _____

Company Name: _____ Phone: _____ Policy# _____

PO Box/Street: _____ Adjuster's name: _____

City/State/Zip: _____