Auto Accident Report

Clark Pitcairn
3737 North Mississippi Avenue, Portland, OR 97227
telephone: 503.467.4511

Name: ______________________ Date of accident: ________________

Please describe or sketch the accident:

Year/make/model of your car: ______________________ other car: ______________________

Total # cars involved: ______________ Est. speed of your car: ______________ other car: ______________

Were you hit from: ☐ Front ☐ Back ☐ Right side ☐ Left side

Were your brakes applied? ☐ yes ☐ no Was your car: ☐ automatic ☐ manual transmission

Were you: ☐ driver ☐ passenger Were you wearing: ☐ lap belt ☐ shoulder belt

Were you aware of the impending collision? ☐ yes ☐ no Road conditions were: ______________

Did you hit anything on the inside of the car? ______________________________

Was there more than one impact? ______________ How many did you feel? ______________

Were there: ☐ Multiple vehicular impacts ☐ Impacts with road barriers (poles, trees, barriers, etc.)

Were you knocked unconscious or dazed? (circle answer) For how long? ______________________

Describe your head position at the time of the impact: ______________________________

Did you notice any bruising/swelling? Where? ______________________________

Have you been examined/treated since the accident (Hospital ER, Dr., etc): ______________________

Was an accident report made? __________ Est. of auto damage: $ __________ Was your car drivable? __________

Have you lost work time as a result of your injuries? ______________ How much? ______________

Have you had any previous accidents resulting injury/treatment? ______________________________

____

INSURANCE INFORMATION:

Your Health Insurance Co. ______________________________________

Address: ______________________________ Policy # ______________

Your Auto Insurance Co. ______________________________ Policy # ______________

Address: ______________________________ Adjuster: ______________

Phone #: ______________________________ Have you reported this accident? ______________

Other Party's Insurance Co. ______________________________ Policy # ______________

Address: ______________________________ Adjuster: ______________

Phone #: ______________________________ Have you been contacted? ______________

Has an attorney advised you in this matter? ______________ Are you being represented? ______________

Attorney Name: ______________________________ Phone # ______________________

Address/City/State/Zip ______________________________________

CONFIDENTIAL CASE HISTORY FILE

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Date: ____________________

Full Legal Name: ______________________________ **Name you prefer:** __________

Address: ______________________________ **City/State/Zip** __________

Phone: (home) ( ) __________ **(work)** ( ) __________ **Soc Sec#** ____-____-____

Birth date: ____/____/____ **Age:** ____ **Sex:** ____ **Marital Status:** S M W D Sep

Spouse's Name: __________ **# Children** ____ **Years of Education** ____

Emergency Contact: ______________________________ **Phone:** ( ) __________

Your Employer: ______________________________ **Phone:** ( ) __________

Employer's Address: ______________________________ **City/State/Zip** __________

Job title: ______________________________ **Supervisor Name:** __________

e-mail address: ______________________________ **Referred by:** __________

MEDICAL HISTORY *(please be complete)*

List any surgeries (include dates & reason): ______________________________

List any hospitalizations (include dates & reason): ______________________________

List any auto accident injuries (include dates): ______________________________

List any on the job injuries (include dates): ______________________________

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

____

List all current over-the-counter and prescription medications used (include reason used):

____

____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

____

Have you been under a physician's care in the past year? ☐ no ☐ yes (reason) __________

When was your last physical examination? ______________________________ **Dr:** __________

Have you ever been under chiropractic care? ☐ no ☐ yes (describe) __________

If female, is there a possibility that you are pregnant? ☐ no ☐ yes

Do you smoke/use tobacco? ☐ no ☐ yes **Exercise habits?** ☐ never ☐ occasional ☐ frequent

Check any of the following symptoms you have noticed: (■ = Previously, ☐ = Now)

■ ☐ Headaches
■ ☐ Dizziness <u>or</u> light-headed
■ ☐ Jaw pain, clicking, <u>or</u> locking
■ ☐ Pain <u>or</u> difficulty swallowing
■ ☐ Neck pain <u>or</u> stiffness
■ ☐ Shoulder pain
■ ☐ Mid back pain
■ ☐ Chest pain <u>or</u> cough
■ ☐ Pain/trouble breathing
■ ☐ Arm/hand numbness/tingling
■ ☐ Arm/hand fatigue/weakness
■ ☐ Low back pain
■ ☐ Leg/foot numbness/tingling
■ ☐ Leg/foot fatigue/weakness
■ ☐ Leg pain with walking
■ ☐ Abdominal pain
■ ☐ Nausea <u>or</u> vomiting
■ ☐ Diarrhea <u>or</u> constipation
■ ☐ Blood in urine <u>or</u> stool
■ ☐ Difficulty <u>or</u> pain w/ urination
■ ☐ Difficulty with sexual function
■ ☐ Abnormal menstrual periods
■ ☐ Sensitive to light <u>or</u> sound
■ ☐ Visual <u>or</u> hearing disturbance
■ ☐ Memory loss/problems
■ ☐ Irritability <u>or</u> depression
■ ☐ Fatigue <u>or</u> loss of energy
■ ☐ Fainting <u>or</u> convulsions
■ ☐ Trouble with balance <u>or</u> coordination
■ ☐ Sleep disturbances/problems
■ ☐ Rashes (face, body, limbs)
■ ☐ Joint pain <u>or</u> swelling
■ ☐ Pain with exertion (activity, climbing stairs, etc.)

HAVE YOU HAD *ANY* OF THE FOLLOWING:

NOW:

☐ Pain worse at night
☐ Constant pain
☐ Unexplained weight loss
☐ Recent bacterial infection (30 days)
☐ Loss of bowel or bladder control
☐ Urinary discharge
☐ Recent surgery (30 days)

EVER:

☐ History of cancer
☐ History of IV drug use
☐ History of blood transfusion

Information about your current condition/complaint

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What is your primary complaint/problem? ______________________

List other symptoms: ______________________

When did your symptoms first begin (give date if possible)? ______________________

How did your symptoms first begin? ______________________

Pain is: ☐ Constant ☐ Intermittent **Is your condition getting worse?** ________

What activities aggravate your condition? (list) ______________________

What activities lessen your symptoms? (list) ______________________

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. ______________________
2. ______________________
3. ______________________

Have you had: ☐ Xray ☐ MRI or CAT Scan ☐ EMG ☐ Bone Scan ☐ Blood Work

Who is your family medical doctor: ______________________

List all home remedies tried for this problem: ______________________

Is your condition worse at certain times of the day or night? ______________________

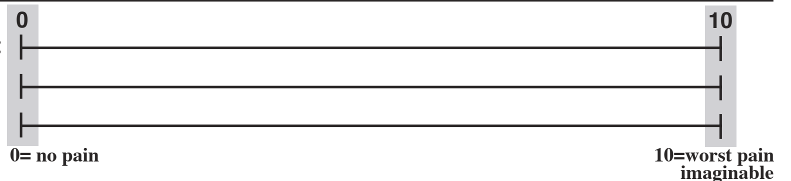
Does your condition interfere with: (yes/no) work ______ sleep ______ normal daily routine ______

Have you had symptoms like this before? ☐ no ☐ yes (describe) ______________________

Regarding your main complaint:

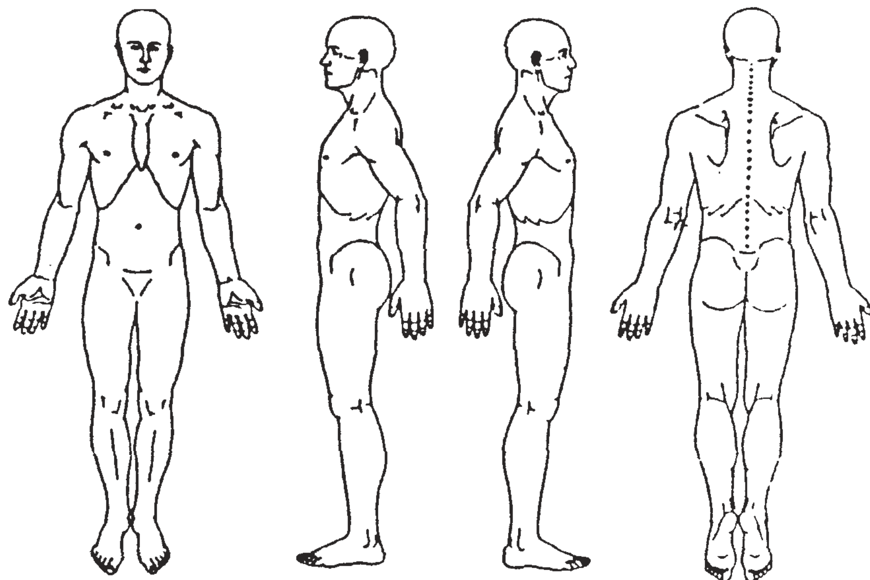
How bad is your pain?
(make a slash on all 3 scales)

1. RIGHT NOW:
2. AVERAGE:
3. AT WORST:



Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
✳ = sharp/stab
ooo = numb/tingle
⟶ = shooting
//// = stiff/tight



Pt. History 3.1
#1.04 SCSI©

NOTICE TO NEW PATIENTS: **Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.**

Patient Signature: ______________________ **Date** ______________