Dr. John J. Collins, Chiropractic Physician
Springbrook Chiropractic & Natural Health Center
1015 N. Springbrook Rd. (Mail to P.O. Box 1022) Newberg, Oregon 97132
(503) 538-0618 fax: 537-2539 www.springbrookclinic.com
"SANITAS INNATUS EST"

HISTORY OF AUTO ACCIDENT/SUBSEQUENT SYMPTOMS

History of Occurrence

Date of accident: _____ Time: _____am/pm Were you alone in car? _ yes _ no
_ Driver Passenger: _front right _front middle _rear right _rear middle _rear left
Driver of car: _____ Who owns the car? _____ Year and model of car: _____
Where was the accident? City: _____Street: _____ Cross Street: _____
Direction of travel: _____
Visibility at time of accident: _ Poor _ Fair _ Good
Road conditions at time of accident: _ Icy _ Rainy and wet _ Clear _ Dark _ wet/not raining
Your car: _ Hit another car _ Was hit….. in the … _ Right _ Left _ Rear _ Front _ Side
Type of accident: _ Head-on-collision _ Broadside collision _ Rear end collision
_ Front impact, rear-ended car in front
_ Non-collision (please describe)

_____

If other vehicles were involved, type of vehicle(s): _____
Describe and draw how the accident happened (note the car you were in as car "A")

_____

Did the police come to the accident scene? _ yes _ no
Did an ambulance come to the accident scene? _ yes _ no
Were you transported by ambulance to the hospital? _ yes _ no If yes, which hospital? _____
What was the approximate damage done to the car you were in? $_____ Was it drivable? _ yes _ no
How much damage was there to the other vehicle? _____ Was it drivable? _ yes _ no

Impact/Seat belt/Headrest/Speed

Seat belt use: Were you wearing a _ Lap belt _ Shoulder belt _ Both _ No belt worn
Were you pre-warned that the accident was about to happen? _ yes _ no
Did you brace for the impact? _ yes _ no

Does your car have headrests? _ yes _ no
If your car does have headrest, 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

Was your car braking? _ yes _ no Was your car moving at the time of the accident? _ yes _ no
If your car was moving, how fast would you estimate you were going? _____mph (estimate)
How fast was the other car traveling? _____ mph (estimate) _ Don't know

Head/Body position

Head/body position at time of impact: _ Head turned left _ Head turned right _ Head looking back
_ Head forward _ Body straight in sitting position
_ Body rotated left _ Body rotated right

Position of right and left arms at time of impact (ie: on steering wheel) _____

Position of right and left feet at time of impact (ie: on brake) _____
Did the impact cause your seat back to slip backward or break? _ yes _ no
Describe, in your own words, what happened to you upon impact: _____
_____
At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
_____
As a result of the accident, you were: _ Rendered unconscious _ Dazed, circumstances vague _ Shaken up but could function
Could you move all parts of your body? _ yes _ no
If no, what body parts could you not move, and why? _____
Were you able to get out of the car and walk unaided? _ yes _ no
Did you get any bleeding cuts or bruises? _ yes _ no
If yes, what bleeding cuts did you get from this accident? _____
If yes, what bruises did you get from this accident? _____
Please describe how you felt immediately after the accident (please be specific) _____
_____

Later that day/night_____ The following days _____

First Doctor/Hospital/Clinic Seen

Did you seek medical help immediately/soon after the accident? _ yes _ no
If yes, who did you first get treatment from? _____
Date of 1st visit: _____
Were you examined? _ yes _ no Were x-rays/MRI's taken? _ yes _ no
Were you given treatment? _ yes _ no If yes, what type of treatment? _____
Date of last treatment: _____

Second Doctor/Hospital/Clinic Seen

Name of Doctor/Hospital/Clinic seen: _____
Date of 1st visit: _____
Were you examined? _ yes _ no Were x-rays/MRI's taken? _ yes _ no
Were you given treatment? _ yes _ no If yes, what type of treatment? _____
Date of last treatment: _____

Third Doctor/Hospital/Clinic Seen

Name of Doctor/Hospital/Clinic seen: _____
Date of 1st visit: _____
Were you examined? _ yes _ no Were x-rays/MRI's taken? _ yes _ no
Were you given treatment? _ yes _ no If yes, what type of treatment? _____
Date of last treatment: _____

Activities of daily living

Do you notice any of your home activities (including domestic duties, social activities, hobbies, sports and recreation) that are different now than before the accident? _ yes _ no
If yes, list them as:
Those activities that you are unable to do (be specific): _____
Those activities that you are now limited due to pain (be specific): _____
Those activities that you are painful but not limited (be specific): _____
Those activities that are not as enjoyable (be specific): _____

Work status history

Have you missed time from work? _ yes If yes, full time off work: _ yes _ no Part time off work: _ yes _ no
_ no
_ Unable to work since the accident
_ I work under duress (work causes my symptoms to increase)

Has your injury increased the level of stress at work? _ yes _ no

Symptoms since accident

_ Disturbed vision	_ Bowel Problems	_ Bladder problems	_ Nausea	_ Disturbed hearing
_ Dizziness	_ Anxiety	_ Depression	_ Breathing difficulty	_ Fatigue
_ Chest pain	_ Weight changes	_ Headaches	_ Nervousness	_ Weakness
_ Balance problems	_ Disturbed sleep	_ Racing heart	_ Decreased appetite	_ Exercise

Prior similar complaints
Did you have any physical complaints just before the accident? _ yes _ no
If yes, what physical symptoms did you have just before the accident? _____

Self/Home treatment that you have used

_ Rest	_ Immobilization	_ Medication	_ Home traction
_ Heating pad	_ Hot shower/bath	_ Cold/Ice	_ Bandages/Braces
_ Stretching	_ Exercise	_ Prayer	_ Meditation
• Massage	_ Limited some activities		

If you did not seek medical or chiropractic care promptly, please explain why:

- Was hoping pain/symptoms would go away in time
- Tried self treatment
- Was worried about the cost
- Didn't know I could go to a chiropractor without a referral from medical doctor
- Other: _____

_____

Thank You! In order for the doctor to provide the highest-quality and most-effective care we require as much information about your health condition/injury as possible.

_____ _____/_____/_____
Patient Signature Today's date