Patient ID:

Auto Accident/Personal Injury Addendum

Doctor's notes:

Patient Name: _____ **Today's Date:** _____

Date of accident/injury: _____ **Patient SS#:** _____-_____-_____

Section 1: Please start here if you were in an auto accident. (Otherwise, please skip to section 2.)

Check all of the following that apply:

- ☐ **I was the driver**
- ☐ **I was a passenger:**
  - ☐ In the front seat
  - ☐ In the back/right
  - ☐ In the back/left
  - ☐ In the back/mid

The vehicle I was in was:

- ☐ Stopped
- ☐ Accelerating@_____mpg
- ☐ Slowing@_____mpg
- ☐ Cruising @_____mpg

Road Condition was:

- ☐ Dry
- ☐ Damp
- ☐ Wet
- ☐ Snow
- ☐ Ice

Time of day:

- ☐ Morning
- ☐ Afternoon
- ☐ Evening/Dusk
- ☐ Night

My vehicle was a:

- ☐ Car
- ☐ Van
- ☐ Truck
- ☐ Bus
- ☐ SUV
- ☐ Motor Cycle

Visibility was:

- ☐ Clear
- ☐ Fair
- ☐ Poor

Impact #1

Collision was with a:

- ☐ **Vehicle**
- ☐ **Object**
- ☐ **Person**

If object or person please describe:							
Vehicle type	Car	Van	Pickup	Truck	Bus	SUV	Motor Cycle
Size and speed	Mini	Sub Compact	Compact	Mid-size	Full-size		
Amount of damage	Minimal	Moderate	Extensive	Totaled	Unsure		

Impact #2

Collision was with a:

- ☐ **Vehicle**
- ☐ **Object**
- ☐ **Person**

If object or person please describe:							
Vehicle type	Car	Van	Pickup	Truck	Bus	SUV	Motor Cycle
Size and speed	Mini	Sub Compact	Compact	Mid-size	Full-size	_____mph	
Amount of damage	Minimal	Moderate	Extensive	Totaled	Unsure		

Impact #3

Collision was with a:

- ☐ **Vehicle**
- ☐ **Object**
- ☐ **Person**

If object or person please describe:							
Vehicle type	Car	Van	Pickup	Truck	Bus	SUV	Motor Cycle
Size and speed	Mini	Sub Compact	Compact	Mid-size	Full-size	_____mph	
Amount of damage	Minimal	Moderate	Extensive	Totaled	Unsure		

Please answer to the best of your recollection:

Were you wearing a seatbelt? Yes / No	Was your body thrown: Yes / No
Air bag deployed? Yes / No	Direction of throw: Forward / Backward / Outside
Brakes applied? Yes / No	Impact was: Unexpected / Expected / Expected and Braced
Seat Broken? Yes / No	Head Position? Straight / Left / Right / Forward
Head Rest: Low / Mid / High / None	Head motion: Front to back / Back to front / Side to side

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Patient ID:

Auto Accident/Personal Injury Addendum

Doctor's notes:

Patient Name: _____ **Today's Date:** _____

Section 2: Please describe your accident in as much detail as possible. Include date, time, place, who was involved, and if there was a traffic citation and/or police report filed. _____

_____

_____

_____

_____

_____

_____

_____

Section 3: Please complete any of the following related to your car accident or personal injury:

Traffic citation? Yes / No If so, who was cited and for what? _____

Police report? Yes / No Police report number and precinct: _____

Body Impact (indicate any parts of your body that were struck during the incident)			
☐ Head	☐ Upper torso/back	☐ Upper torso/front	☐ Mid Torso
☐ Left Shoulder	☐ Left Arm	☐ Left Elbow	☐ Left Hand
☐ Right Shoulder	☐ Right Arm	☐ Right Elbow	☐ Right Hand
☐ Left Hip	☐ Left Knee	☐ Left Foot	☐ Abdomen
☐ Right Hip	☐ Right Knee	☐ Right Foot	☐ Low back
Pain experienced immediately after accident:			
☐ Head	☐ Neck	☐ Chest	☐ Upper Back
☐ Mid-back	☐ Lower back	☐ Abdomen	☐ Tailbone
☐ Left Shoulder	☐ Left Arm	☐ Left Elbow	☐ Left Hand
☐ Right Shoulder	☐ Right Arm	☐ Right Elbow	☐ Right Hand
☐ Left Hip	☐ Left Knee	☐ Left Foot	Other: _____
☐ Right Hip	☐ Right Knee	☐ Right Foot	_____
After accident information:			
☐ Dizzy/dazed	☐ Agitated	☐ Weakness	☐ Nervous/anxious
☐ Headache	☐ Disoriented	☐ Unconscious	☐ Vomiting
Numbness immediately after accident:			
☐ Left Hand	☐ Left Arm	☐ Left Foot	☐ Left Leg
☐ Right Hand	☐ Right Arm	☐ Right Foot	☐ Right Leg
Did you receive any other care prior to coming to this office? Yes / No			
Date of care: _____		Who transported you? _____	
☐ Hospital admission	☐ Orthopedic	☐ Chiropractor	☐ Family Dr.
☐ X-Ray	☐ Labs	☐ MRI	☐ CT scan
Other (specify): _____		Treatment: _____	

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Doctor's notes:

Patient Name: _____ **Today's Date:** _____

Please note any symptoms that began after the accident occurred:			
☐ Head	☐ Upper torso/back	☐ Upper torso/front	☐ Mid Torso
☐ Left Shoulder	☐ Left Arm	☐ Left Elbow	☐ Left Hand
☐ Right Shoulder	☐ Right Arm	☐ Right Elbow	☐ Right Hand
☐ Left Hip	☐ Left Knee	☐ Left Foot	☐ Abdomen
☐ Right Hip	☐ Right Knee	☐ Right Foot	☐ Low back
Pain experienced immediately after accident:			
☐ Head	☐ Neck	☐ Chest	☐ Upper Back
☐ Mid-back	☐ Lower back	☐ Abdomen	☐ Tailbone
☐ Left Shoulder	☐ Left Arm	☐ Left Elbow	☐ Left Hand
☐ Right Shoulder	☐ Right Arm	☐ Right Elbow	☐ Right Hand
☐ Left Hip	☐ Left Knee	☐ Left Foot	Other: _____
☐ Right Hip	☐ Right Knee	☐ Right Foot	_____
After accident information:			
☐ Dizzy/dazed	☐ Agitated	☐ Weakness	☐ Nervous/anxious
☐ Headache	☐ Disoriented	☐ Unconscious	☐ Vomiting
Numbness immediately after accident:			
☐ Left Hand	☐ Left Arm	☐ Left Foot	☐ Left Leg
☐ Right Hand	☐ Right Arm	☐ Right Foot	☐ Right Leg

Did you receive any other care prior to coming to this office? Yes / No

Date of care: _____		Who transported you? _____	
☐ Hospital admission	☐ Orthopedic	☐ Chiropractor	☐ Family Dr.
☐ X-Ray	☐ Labs	☐ MRI	☐ CT scan
Other (specify): _____		Treatment: _____	

Section 4: Please answer the following regarding past injuries and accidents:

Please describe previous injuries or accidents here: _____

_____

_____

Who did you see?	Orthopedic Neurologist Family Doc ER/Urgent care Chiropractor Other None

Treatment given:_____

_____

Please describe any residual pain you have from prior accidents and injuries: _____

_____

_____

_____

_____

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Section 5: Please note any symptoms that you are having now as a result of your recent accident

Head			
☐ Headache	☐ Dizziness	☐ Blurred Vision	☐ Light Headedness
☐ Fainting	☐ Memory Loss	☐ Sharp, shooting pain	☐ Double Vision
☐ Other (specify): _____			
Neck (when moving)			
☐ Pain in neck	☐ Bending forward	☐ Bending back	☐ Turning left
☐ Turning right	☐ Bending left	☐ Bending right	☐ Popping in neck
☐ Muscle spasms	☐ Torticollis	☐ Tingling in arms or hands when moving neck	
☐ Other (specify): _____			
Shoulders			
☐ Pain within the joint	☐ Tension in shoulders	☐ Muscle spasms	☐ Pain across shoulder
☐ Can't raise arms	Over head	Above shoulder level	Above waist level At all
☐ Other (specify): _____			
Arms and Hands			
☐ Pain in fingers	☐ Numbness (lt arm)	☐ Numbness (rt arm)	☐ Cold hands
☐ Pins and needles	☐ Loss of strength	☐ Swollen joints	☐ Pain in elbow
☐ Other (specify): _____			
Chest			
☐ Chest Pain	☐ Pain in ribs	☐ Pain with breathing	☐ Shortness of breath
☐ Breast pain	☐ Bruising (belt injury)	☐ Wheezing	☐ Coughing blood
☐ Other (specify): _____			
Abdomen			
☐ Nervous stomach	☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Constipation	☐ Gas	☐ Distention/bloat	☐ Bruising
☐ Other (specify): _____			
Mid Back			
☐ Sharp stabbing	☐ Mid back pain	☐ Through pain	☐ Dull ache
☐ Pain near kidneys	☐ Muscle spasms	☐ Between shoulders	☐ Bruising
☐ Other (specify): _____			
Lower back			
☐ Low back pain: ☐ Muscles spasms	Worse with: Working Lifting Stooping Standing Sitting Bending Coughing/sneezing Lying down Other (specify):		
Hips, legs and feet			
☐ Buttock pain	☐ Pins and needles	☐ Muscle weakness	☐ Cramping
☐ Pain down leg	☐ Pain in hip	☐ Cold or swollen feet	☐ Knee pain
☐ Other (specify): _____			

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