

Hoffmann Chiropractic
310 Maple Ave L 04
Barrington RI 02806
401-289-2444

Automobile Accident/P.I.

Name: _____ Date: _____

Date of Accident: _____ Date of EXAMINATION: _____

HISTORY: - Automobile Accident/P.I.

____ Driver ____ Passenger ____ Pedestrian ____ Other: _____

Traveling Direction or Stopped facing: NORTH SOUTH EAST WEST

Estimated speed of patient's vehicle: _____ Estimated speed of other vehicle: _____

Location of Accident: Street: _____ City: _____ State: _____

DESCRIPTION OF ACCIDENT (*Check and/or circle the appropriate description*)

- ____ Stopped/slowing down for traffic/red light/stop sign) and was rear-ended by another vehicle.
- ____ Was pushed into the vehicle in front of his/hers.
- ____ Slowing down to execute a turn and was struck in the rear by another vehicle.
- ____ Was side swiped by another vehicle traveling in the same direction.
- ____ Another vehicle ran a (red light/stop sign) and struck (his/her) vehicle broadside/in the rear/in the front.
- ____ The vehicle in which (he/she) was riding, was struck by another vehicle causing it to spin/roll over.
- ____ Involved in a multi-car collision.
- ____ Was thrown from the vehicle to the pavement/ground/outside object/another vehicle.
- ____ Was a pedestrian and was struck by a motor vehicle in an accident.
- ____ Other (brief description): _____

Did the vehicle have seatbelts? YES NO Were you braced for the impact? YES NO
Were you wearing seatbelt? YES NO Were the brakes applied? YES NO

List your seat position in the vehicle: _____

Was the position of your headrest: _____ Directly behind your head
____ Below the mid point of the back of your head.
____ Absent

At the time of impact, was the position of your head: STRAIGHT TURNED RT. TURNED LT.

Did you strike any object inside the car? YES NO

Which body parts struck any objects at the time of impact:

____ Head ____ Face ____ Chest ____ Neck ____ Back ____ Shoulder (Rt/Lt)
____ Arm (Lt/Rt) ____ Knee (Rt/Lt) ____ Leg (Rt/Lt) Other: _____

Which objects were struck:

____ Windshield ____ Headrest ____ Dash Board
____ Steering Column ____ Door Frame ____ Rear view mirror
____ Back of seat ____ Seat broke ____ Cannot remember
____ Other: _____

Were you rendered: ____ Unconscious ____ Cut or Bleeding ____ Neither

If applicable, indicate any pains or abnormal sensations experienced, immediately following the accident:

- | | |
|---|--|
| <input type="checkbox"/> Felt no immediate pain. | <input type="checkbox"/> Pain began several hours/days/weeks after accident. |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Saw stars |
| <input type="checkbox"/> Semi-conscious state | <input type="checkbox"/> Neck Pain (Rt/Lt) |
| <input type="checkbox"/> Mid back pain (Rt/Lt) | <input type="checkbox"/> Low back pain (Rt/Lt) |
| <input type="checkbox"/> Upper extremity pain (Rt/Lt) | <input type="checkbox"/> Lower extremity pain (Rt/Lt) |
| <input type="checkbox"/> Other: _____ | |

Indicate any actions taken immediately following the accident:

- Went home and took it easy.
- Went about normal business.
- Went to other Chiropractic office.
- Went to hospital.
- Went to family physician.
- Used over-the-counter medications thinking symptoms would eventually "go away".

HOSPITALIZATION: (If no hospital visit, skip to next section)

Indicate method of delivery to hospital: Ambulance Driven by family, friend, etc.
 Drove yourself Other: _____

Hospital: Sacred Heart Luther Midelfort Other: _____

Were you seen in the emergency room? YES NO

Were you admitted to the hospital? YES NO (If yes, length of stay? _____)

Indicate which procedures were performed while at hospital (including emergency room):

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> Examination | <input type="checkbox"/> Stitches | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Prescription/Meds | <input type="checkbox"/> Injections | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Wounds dressed | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Bed Rest |

What did you do after being released from hospital? _____

Who was the first physician you consulted after this accident? (If this is first office, skip to PAST HISTORY)

Name & office location: _____

Was this physician: Family Physician Chiropractor
 Neurologist Orthopedist
 OBGYN Other: _____

What procedures were conducted: Examination X-rays
 Traction Given medications.
 Manipulation Refer to Physical Therapy
 Other: _____

If Physical Therapy was used, where did you receive therapy? _____

Have you seen other physicians since the above physician? YES NO

If yes, name & location of physician(s): _____

Are you still under the care of the physician(s)? YES NO

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PAST HISTORY:

Has the patient been involved in any previous automobile accidents, of any kind? YES NO

If yes, indicates dates & details: _____

Have you ever been treated for any other past conditions that might relate to the injuries you have suffered in this recent accident? YES NO If yes, explain: _____

Have you ever undergone any surgeries or experienced any conditions that you feel are pertinent to your current condition? YES NO If yes, explain: _____

Did you enjoy good health prior to this accident? YES NO – explain: _____

Your signature below will verify that all information you have given is accurate and complete

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____