CYNERGY
HEALTH & WELLNESS

Motor Vehicle Accident History

Patient Information

Dr./Mr./Mrs./Ms./Miss (circle one) Marital status (circle one) M S W D
Last Name_____ First Name_____ Middle Initial___
_____
Address City State Zip Code
Home phone#_____ Work phone# _____ Cell phone#_____
Email address_____
Social Security No._____ Date of Birth _____ Sex [ ] M [ ] F
Occupation_____ Employer _____
Work Address_____
Person to contact in an emergency _____
Phone#_____ Relation to Patient _____

Responsible Party

Name of person responsible for payment of this account_____
Relation to patient_____ Phone#_____
_____
Address City State Zip Code

Insurance Information

If you have any insurance information, please give to our front desk staff.

Accident/Injury History

1. Date of Accident: _____ Time of Day: _____ Road Condition: ( ) Dry ( ) Wet
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____
4. Were you wearing a seat belt? ( ) Y ( ) N If no, go to question #6
5. If yes, were you wearing a lap belt? ( ) Y ( ) N shoulder harness? ( ) Y ( ) N
6. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
(Name of street and city):_____

7. What direction was the other vehicle headed? ( ) North ( ) South
( ) East ( ) West
(Name of street and city):_____
8. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
Other combination, please describe: _____
9. What was the position of your head during the accident? ( ) Straight ( ) Turned Right ( ) Turned Left ( ) Other_____
10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc.)? ( ) Y ( ) N If yes, please explain:
_____
11. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)? ( ) Y ( ) N If yes, please describe:
_____
12. Approximate speed of your car: _____ mph
Estimated speed of the other car: _____ mph
13. Make/model of your car: _____
Make/model of the other vehicle: _____
14. Were the police notified? ( ) Y ( ) N Please provide this office with a copy of the police report.
15. In your own words, please describe the accident:
_____
_____
_____
16. Did you have any physical complaints BEFORE the accident? ( ) Y ( ) N
If yes, please describe in detail: _____
17. Please describe how you felt:
a. DURING the accident: _____
b. IMMEDIATELY AFTER the accident: _____
c. LATER THAT DAY: _____
d. THE NEXT DAY: _____
18. Were you knocked unconscious? ( ) Y ( ) N If yes, for how long? _____
19. Where were you taken after the accident? _____
20. Have you been treated by another doctor since this accident? ( ) Y ( ) N
If yes, please list the doctor's name and address: _____
_____
What type of treatment did you receive? _____
_____
21. Did this accident occur while you were performing your regular job duties? ( ) Y ( ) N
22. How do you feel now, what is your number one problem or the one area of greatest pain? _____
_____
23. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.

0 1 2 3 4 5 6 7 8 9 10

24. Since this injury occurred, is your pain: ( ) Improving ( ) Getting Worse
( ) Staying the Same

25. How often do you experience the pain?

___ 1-2 hours per day ___ About half of the day

___ Most of the day ___ The pain never goes away

26. How does the pain affect your daily activities?

___ It does not affect my daily activities

___ I have had to change how I do things

___ I have had to stop doing some of my daily activities

___ I am unable to perform daily activities

27. What increases your pain? _____

28. What decreases your pain? _____

29. Have you ever experienced this problem before? [ ] Y [ ] N When? _____

30. Do you have a previous illness/disease which affects your present condition? ( ) Y ( ) N

If yes, please describe: _____

31. List any other complaints currently bothering you and rate your pain level for each.

a._____ 0 1 2 3 4 5 6 7 8 9 10

b._____ 0 1 2 3 4 5 6 7 8 9 10

c._____ 0 1 2 3 4 5 6 7 8 9 10

d. _____ 0 1 2 3 4 5 6 7 8 9 10

32. Have you lost time from work as a result of this accident? ( ) Y ( ) N

a. Type of employment: _____

b. Last day worked: _____

33. Have you ever been involved in an accident before? ( ) Y ( ) N

a. If yes, when? _____

b. Describe the accident(s):_____

_____

c. Were you injured? [ ] Y [ ] N Explain:

_____

34. List all medication you are currently taking (prescribed and over counter)

_____

35. List all surgeries you have had (with date)

_____

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (Check all that apply)

___ heart attack ___ stroke ___ arthritis ___ gall bladder trouble
___ diabetes ___ glaucoma ___ fainting spells ___ kidney stones
___ difficulty with urination ___ bloody stools ___ difficulty with bowel movements
___ prostate trouble ___ anemia ___ cancer ___ asthma
___ AIDS ___ ulcers ___ diverticulosis ___ menstrual cramping
___ dizziness ___ loss of memory ___ chest pain ___ shortness of breath
___ constipation ___ diarrhea ___ general fatigue ___ sudden weight loss
___ nausea ___ muscle cramping ___ soreness in joints ___ loss of hearing
___ ears ringing ___ headache ___ migraine ___ epilepsy
___ gout ___ tuberculosis ___ syphilis ___ sprained ankle [ ] R [ ] L
___ knee/hip replacement ___ broken bones (specify)

General Activities (check all that apply)

___ sleep on waterbed ___ read in bed ___ fall asleep in recliner/on couch
___ sleep on stomach ___ sleep with 2 or more pillows
___ needlepoint/knitting ___ sewing ___ lift weights
___ swim ___ jog/run ___ other form of exercise
___ play video games (__ hrs/day) ___ computer use (__ hrs/day)
___ watch television (__ hrs/day)

Please add anything else you would like the doctor to know:

_____
_____
_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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

Office Use Only:

Doctor's Notes/Comments:

_____
_____
_____