WALKER ROAD CHIROPRACTIC
Chiropractic, Rehab & Massage

Personal Injury History Form

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

Accident Details

-**Date of accident**: _____ **Time of day**: _____

-**Number of vehicles involved in crash**: _____

-**Estimated cost of damage to your vehicle**: _____

-**Estimated cost of damage to other vehicle(s):** _____

-**Location accident occurred at and direction you were traveling at time of accident**: North South East West

Street: _____ **City**: _____ **State**: _____

-**Were you struck by another vehicle or did you run into someone else? (Please explain how the vehicles collided with each other)**_____

_____

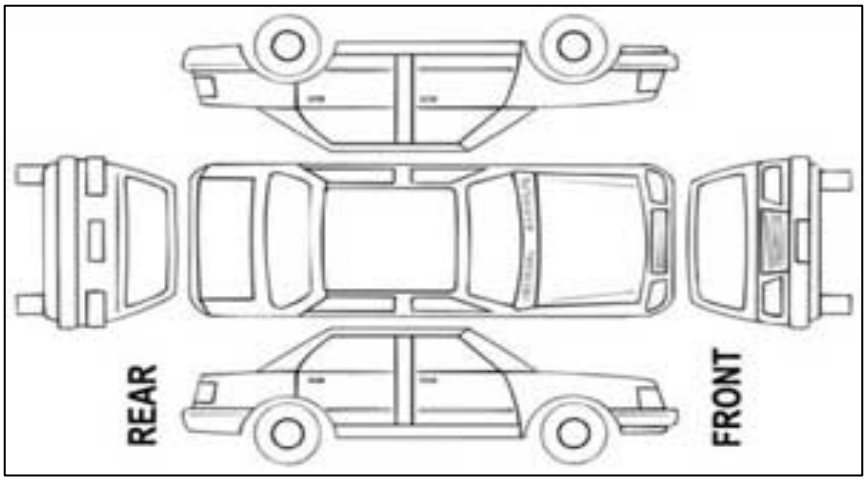
_____

_____

_____

_____

Please diagram the damage to your car that during the accident



-**Did you see the accident coming?** □ Yes □ No

-**Did the airbags deploy?** □ Yes □ No

-**Were you driving?** □ Yes □ No **If not, where were you seated?**_____

-**What kind of car were you driving?** _____

-**What size of vehicle collided with you?** □ Mini □ Compact □ Midsized □ Full sized □ Industrial

-**What type of vehicle collided with you?** □ Sedan □ SUV □ Truck □ Van

-**How did your vehicle move during the crash?** Kept going straight, rolled over, spun, pushed forward, pushed sideways

Other: _____

-**Were you wearing a safety belt?** □ Yes □ No **If "yes" what kind?** □Lap belt □Shoulder strap □Both

- Did you remain in your seatbelt during the accident? □ Yes □ No

-**Did you have a headrest?** □ Yes □ No **If "yes" what was the height/positioning? Select all that apply:**

□Higher than head □Middle □Lower than head □Touching head □Not touching head □Fixed □Moveable

Your body during the accident

-**What position was your head during the accident?** Looking forward, Looking right, Looking left, Tilted right, Tilted left

-**What position was your torso during the accident?** Turned right, Turned left, Bent forward, Upright, Tilted right, Tilted left

-**What position were your hands during the accident?** In lap, On the wheel, On gearshift, On ceiling handle, On window sill

Other: _____

-Did any part of your body strike any part of the car? (explain)_____

_____

_____

-Loss of consciousness? □ Yes □ No *if "yes", please explain*: _____

-Were you stunned? □ Yes □ No *If "yes", how long*? _____

- **Did you feel or hear popping, tearing, or ripping noises in your neck or back?** □ Yes □ No

if "yes", please explain:_____

Did you feel any pain? □ Yes □ No *if "yes" where?*_____

How long after the accident? _____

Did you find any bruises? □ Yes □ No *if "yes", where?* _____

List the extent of your injuries as you know them: _____

_____

_____

Please check any symptoms that you have experienced since the accident.

□Headache
□Skull or head pain
□Neck pain
□Neck stiffness
□Head feels too heavy
□Shoulder pain
□Shoulder stiffness
□Arm pain
□Arm Numbness
□Pins and needles in arms
□Numbness in hands/fingers
□Cold hands
□Upper back pain
□Upper back stiffness
□Mid back pain
□Mid back stiffness
□Chest pain
□Rib pain
□Painful breathing

□Low back pain
□Low back stiffness
□Hip pain
□Buttock pain
□Leg pain
□Leg numbness
□Pins and needles in legs
□Numbness in feet/toes
□Cold feet
□Depression
□Anxiety
□Tension
□Irritability
□Nervousness
□Mental dullness
□Loss of memory
□Difficulty sleeping
□Fatigue
□Tremors

□Face flushed
□Loss of color
□Dizziness
□Fainting
□Sinus trouble
□Loss of smell
□Eye stain
□Difficulty focusing
□Pain behind eyes
□Eyes sensitive to light
□Double Vision
□Buzzing or ringing in ears
□Loss of balance
□Palpitations
□Shortness of breath
□Digestive problems
□Nausea
□Vomiting
□Diarrhea

□Constipation
□Excessive perspiration
□Loss of perspiration
□Loss of taste
□Cold sweats
□Fever
□Swelling, where: _____
□Difficulty in:
  □Prolonged
  □Excessive
    □Riding in car
    □Bending
    □Standing
    □Sitting
    □Walking
    □Lifting
  □Twisting/Turning
  □Difficulty rising to walk
  □Pain doing occupation

-Did you require post-accident care or hospitalization? □ Yes □ No *if "yes", where?*_____

-Were you examined? □ Yes □ No *if "yes" by whom*? _____

-Were you X-rayed? □ Yes □ No *if "yes" by where*? _____

-What is your occupation? _____ **Job duties affected by symptoms?** _____

_____

Have you missed work as a result of this accident? □ Yes □ No *If "yes" how many days?* _____

Please select any concerns you may have about your symptoms: _____

□ It could be serious □ Getting worse □ Affecting relationships □ Not going away □ Affecting work

□ Affecting emotional wellbeing □ Affecting recreational activities □ Affecting leisure activities

Patient's or Guardian's signature: _____ **Date**:_____