MONTGOMERY
CHIROPRACTIC
PLUS

PERSONAL INJURY PATIENT DATA FORM

PART 1

DATE OF ACCIDENT______________________________________TIME____________________(AM/PM)
WERE YOU DRIVING? (YES/NO) IF NOT, WHERE WERE YOU SEATED________________________
WHO OWNS THE CAR_______________________YEAR AND MODEL OF CAR_____________________
WHAT WAS THE APPROXIMATE DAMAGE TO YOUR CAR? $__________________________________
VISIBILITY AT THE TIME OF THE ACCIDENT (POOR/FAIR/GOOD/OTHER)_________________
ROAD CONDITIONS AT TIME OF ACCIDENT (ICY/RAINY WET/CLEAR/DARK/OTHER)_____
WHERE WAS YOUR CAR STRUCK? (RIGHT/LEFT/REAR/FRONT/SIDE/OTHER)____________
TYPE OF ACCIDENT (_____) HEAD ON COLLISION (_____) BROAD SIDE COLLISION
(_____) REAR END COLLISION (_____) REAR END CAR INFRONT
(_____) NON COLLISION____
DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED TO YOU ON IMPACT ___________________
____
DID YOU SEE THE ACCIDENT COMING? (YES/NO)
DID YOU BRACE FOR IMPACT (YES/NO)
WERE SEAT BELTS WORN (YES/NO)
WERE SHOULDER HARNESSES WORN (YES/NO)
DOES YOUR CAR HAVE A HEAD REST? (YES/NO)
IF YES, WHAT WAS THE POSITION OF THE HEAD REST COMPARED TO YOUR HEAD?
(_____) TOP OF HEAD REST EVEN WITH BOTTOM OF HEAD
(_____) TOP OF HEAD REST EVEN WITH TOP OF HEAD
(_____) TOP OF HEAD REST EVEN WITH MIDDLE OF NECK
WAS THE CAR BREAKING? (YES/NO)
WAS YOUR CAR MOVING AT THE TIE OF THE ACCIDENT? (YES/NO)
IF YES, HOW FAST WOULD YOU ESTIMATE YOU WERE GOING? ___________________KM/H
HEAD/BODY POSITION AT TIME OF IMPACT
(_____) HEAD TURNED LEFT/RIGHT (_____) BODY STRAIGHT IN SITTING POSITION
(_____) HEAD LOOKING BACK (_____) BODY ROTATING LEFT/RIGHT
(_____) HEAD STRAIGHT FORWARD (_____) OTHER______________________________
AT THE TIME OF THE ACCIDENT, RECALL WHAT PARTS OF YOUR HEAD OR BODY HIT WHAT PARTS OF THE INSIDE OF YOUR CAR ____
____
AS A RESULT OF THE ACCIDENT YOU WERE
(_____) RENDERED UNCONSCIOUS
(_____) DAZED, CIRCUMSTANCES VAGUE
(_____) OTHER____

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COULD YOU MOVE ALL PARTS OF YOUR BODY? (YES/NO) IF NO, WHAT PARTS AND WHY?

____

WERE YOU ABLE TO GET OUT OF THE CAR AND WALK AROUND? (YES/NO)
IF NO, WHY NOT? ____
WHAT BLEEDING CUTS DID YOU GET FROM THE ACCIDENT? ______________________________
WHAT BRUISES DID YOU GET FROM THE ACCIDENT? ____________________________________
PLEASE DESCRIBE HOW YOU FELT IMMEDIATELY AFTER THE ACCIDENT
LATER THAT DAY____________________LATER THAT NIGHT__________________________
THE NEXT DAY______________________THE FOLLOWING DAYS________________________
CHECK SYMPTOMS APPARENT SINCE THE ACCIDENT

(____) HEADACHE (____) LOSS OF SMELL (____) NUMBNESS IN FINGERS
(____) NECKPAIN/STIFF (____) LOSS OF TASTE (____) COLD HANDS
(____) MID BACK PAIN (____) LOSS OF MEMOR (____) COLD FEET
(____) LOW BACK PAIN (____) FATIGUE (____) DIARRHEA
(____) EYES SENSITIVE (____) TENSION (____) CONSTIPATION
(____) PAIN BEHIND EYE (____) SHORT OF BREATH (____) CHEST PAIN
(____) DIZZYNESS (____) IRRITABILITY (____) NERVOUSNESS
(____) FAINTING (____) DEPRESSION (____) COLD SWEATS
(____) RINGING IN EARS (____) SLEEPING PROBLEMS (____) ANXIOUS
(____) LOSS OF BALANCE (____) NUMBNESS IN TOES (____) OTHER______________________

PART 2

OCCUPATION________________________________EMPLOYER_______________________________
HAVE YOU MISSED TIME FROM WORK? (YES/NO)
FULL TIME OFF WORK FROM ____________________________TO_____________________________
PART TIME OFF WORK FROM ____________________________TO _____________________________
BEEN UNABLE TO WORK SINCE ACCIDENT (YES/NO)
DID YOU SEEK MEDICAL HELP IMMEDIATELY/SOON AFTER ACCIDENT? (YES/NO)
IF YES, HOW DID YOU GET THERE? ____
(___) SOMEONE DROVE ME (____) AMBULANCE (___) POLICE
(___) DROVE OWN CAR (____) OTHER____

PART 3

DOCTER/HOSPITAL/CLINIC SEEN____
WERE YOU EXAMINED (YES/NO)
WERE X-RAYS TAKEN (YES/NO) IF YES WHAT BODY PART _________________________________

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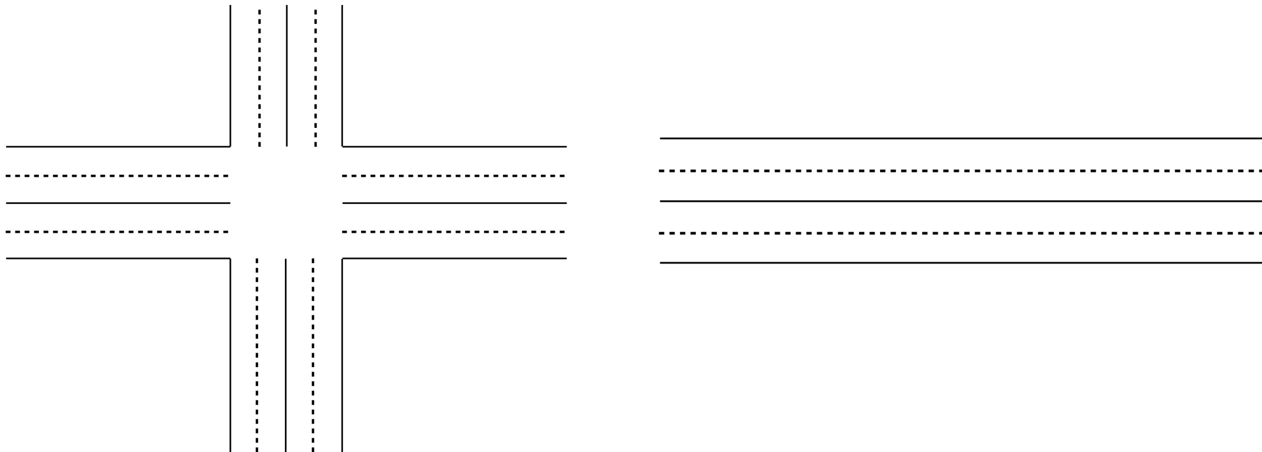
WHAT TREATMENT WAS GIVEN TO YOU?
(_____) BED REST (_____) BRACE (_____) PHYSIO (_____) OTHER________________________
WHAT BENEFITS DID YOU RECEIVE FROM TREATMENT? ______________________________________
____
DATE OF LAST TREATMENT ___________________________________
DID YOU HAVE ANY PHYSICAL COMPLAINTS JUST BEFORE THE ACCIDENT? (YES/NO)
IF YES PLEASE DESCRIBE ____
PRIOR TO THE ACCIDENT, HAVE YOU EVER HAD SYMPTOMS SIMILAR TO WHAT YOU ARE EXPERIENCING NOW? (YES/NO) IF YES, PLEASE DESCRIBE ___________________________________
____
DO YOU NOTICE ANY ACTIVITIES OF YOUR DAILY HOME ROUTINE THAT ARE DIFFERENT NOW, THAN BEFORE THE ACCIDENT? (YES/NO) IF YES, PLEASE CLASSIFY AS:
THOSE YOU ARE UNABLE TO DO ____
THOSE THAT ARE DIFFICULT TO DO ____
THOSE THAT ARE PAINFUL TO DO ____

PART 4
INDICATE ON THE DIAGRAM HOW THE ACCIDENT HAPPENED AND WHICH CARE YOU WERE IN.



DRAW YOUR OWN