PINEHURST CHIROPRACTIC **DAVID KIRDAHY DC**

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

AUTO ACCIDENT MECHANISM OF INJURY FORM

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

1. Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**
2. a) What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**
   b) If "Driver," were your hands on the steering wheel? **Both** / **Left** / **Right**
3. Did the airbags deploy? **Yes** / **No**
4. What type and year of vehicle were you in? _____
5. What was the approximate speed of your vehicle when the accident occurred? _____mph
6. What was the Direction of Impact: **Left / Right / Front / Rear / Other**: _____
7. a) Did you strike a second vehicle? **Yes** / **No** Did a second vehicle strike your vehicle? **Yes** / **No**
   b) If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**:_____
8. What type and year of vehicle struck yours?_____
9. What was the approximate speed of the other vehicle when the accident occurred? _____ mph
10. In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**
11. a) Were you aware of the impending impact? **Yes** / **No**
    b) If "NO", how did you brace? **With Hands** / **With Feet**
12. a) Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**
    b) Were you leaning forward at the time of impact? **Yes** / **No**
13. Was your car smaller or larger than the other car? _____
14. Did you feel pain immediately after the accident? **Yes** / **No**
    Where? _____
    What Kind? _____
15. Were you rendered unconscious as a result of the accident? **Yes / No**
16. Did you strike anything in the vehicle at the time of impact? **Yes** / **No**
    If Yes, please specify which part of your body hit which part of the car:
    _____
    _____
17. Did your seat break or bend? **Yes** / **No**
18. Immediately following the accident, did you feel any of the following symptoms?
    (Circle all that apply) **Dizziness / Loss of Range of Motion / Visual Disturbance / Anxiety / Depression / TMJ** / **Other**: _____

PLEASE COMPLETE BOTH SIDES

2611 NE 125th #115, Seattle, WA 98125 **(206) 365-2233 Fax (206)361-7082**

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

19. Do you currently have problems with **Work, Studies/School, Domestic Duties,** or **Household Duties** since the accident? (please circle) **Other**?_____

20. Do you currently have loss of enjoyment in **Work, Studies, School, Domestic Duties, Household Duties,** or **Sports**, due to the accident? (Please Circle) **Other**? _____

POLICE AND AMBULANCE:

1. Was the accident reported to the police? **Yes** / **No**
2. Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____
3. a) Did you go to the hospital? **Yes** / **No** If "YES", when? _____
   b) If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**
   c) Were you admitted? **Yes** / **No** If "YES", how long? _____
   d) Name of Hospital? _____ Attended by Dr. _____
   e) What treatment were you given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches / Muscle Relaxants** / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** / **Other**: _____
   f) What other doctor have you seen as a result of this injury? _____
4. Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**
5. Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

AUTO ACCIDENT INSURANCE

CARRIER		**POLICY NUMBER**	
ADDRESS			
CITY	**STATE**	**ZIP**	**PHONE**
PERSON TO CONTACT…		**CLAIM #**	
DATE OF ACCIDENT	**PATIENT RELATIONSHIP TO THE INSURED**	**SELF**	**SPOUSE**
CHILD	**OTHER**		

_____ _____

Patient Signature **Date**

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PATIENT'S NAME: _____ **TODAY'S DATE:** _____

REASON FOR SEEKING CHIROPRACTIC CARE

SYMPTOM 1 _____

1. On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
2. What percentage of the time you are awake do you experience the above symptom at the above intensity**: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
3. When did the symptom begin? _____
   a) Did the symptom begin suddenly or gradually? (circle one)
   b) How did the symptom begin? _____
   c) Did you have this symptom before this motor vehicle collision? Yes/No_____
   d) If so, what was the intensity (1-10 w/10 the worst) and frequency? _____
4. What makes the symptom worse? (circle all that apply):
   a) Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
   _____
5. What makes the symptom better? (circle all that apply):
   Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
6. Describe the quality of the symptom (circle all that apply):
   Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
7. Does the symptom radiate to another part of your body (circle one): **Yes** **No**
   a. If yes, where does the symptom radiate? _____
8. Is the symptom worse at certain times of the day or night? (circle one)
   Morning **Afternoon** **Evening** **Night** **Unaffected by time of day**

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REASON FOR SEEKING CHIROPRACTIC CARE

SYMPTOM 2 _____

1. On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
2. What percentage of the time you are awake do you experience the above symptom at the above intensity**: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
3. When did the symptom begin? _____
   a) Did the symptom begin suddenly or gradually? (circle one)
   b) How did the symptom begin? _____
   c) Did you have this symptom before this motor vehicle collision? Yes/No_____
   d) If so, what was the intensity (1-10 w/10 the worst) and frequency? _____
4. What makes the symptom worse? (circle all that apply):
   Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
   _____
5. What makes the symptom better? (circle all that apply):
   Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
6. Describe the quality of the symptom (circle all that apply):
   Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
7. Does the symptom radiate to another part of your body (circle one): **Yes** **No**
   a. If yes, where does the symptom radiate? _____
8. Is the symptom worse at certain times of the day or night? (circle one)
   Morning **Afternoon** **Evening** **Night** **Unaffected by time of day**

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