Healing Spirit Touch, Inc.
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503-245-0454

HISTORY OF AUTO ACCIDENT/SUBSEQUENT SYMPTOMS

Patient Name:_____

Date of accident: _____ Time: _____am/pm # of people in vehicle:_____

Circle One:

You were the:
Driver or Passenger: Front Rear: Behind Driver Middle Behind Passenger

Your car:
Hit another car or Was hit in the … Rear Front Side

Where was the accident?
City: _____Street: _____ Cross Street:_____

Type of car you were in: _____ other vehicle(s):_____

Description of Accident:
_____
_____
_____
_____

Did the police or ambulance come to the accident scene? No Yes

Were you wearing a seatbelt? No Yes AirbagsDeployed? No Yes

Did you brace for the impact? No Yes

Explain Head/arm/body position at time of impact:
_____

Did any part of your body hit inside the vehicle? No Yes
Explain:_____

Did you get any cuts or bruises? No Yes
Where?
_____

Did you go to hospital or see another doctor? No Yes Date of 1st visit: _____

Were x-rays/MRI's taken? No Yes
Explain:_____

Were you given treatment? No Yes
If yes, what type of Treatment?_____

Do you feel you can work without pain? No Yes
What is your job? _____

Similar symptoms in the past? No Yes
Explain:_____

Past Health History

Do you take any medications? No Yes
Explain:_____

Past Surgeries/Hospital Stays? No Yes
Explain:_____

Past Injuries or Broken Bones? No Yes
Explain:_____

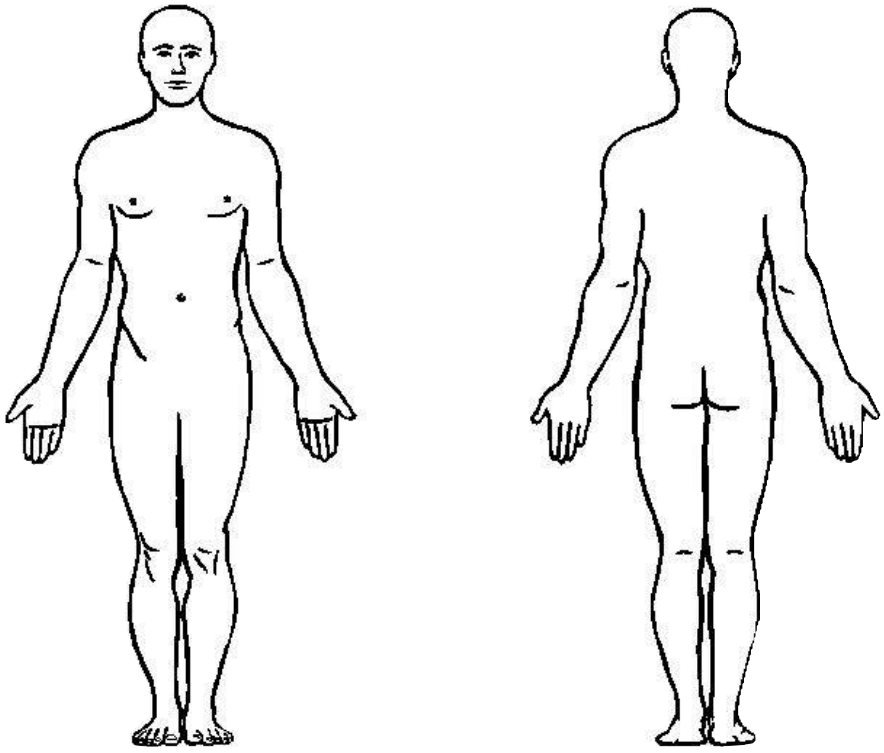
Previous and Current Illnesses? No Yes
Explain:_____

Family History:

_____

_____

Current Complaints: Indicate P = Pain. T= Tightness, S= Swelling, B= Burning, L= Limited Movement



Other notes:

Signature: _____ Date: ____/____/____