Amberwood Terrace Chiropractic
Derrick R. Hendricks D.C.
663 CR 17, Suite 3
Elkhart IN 46516
574-522-2255

Auto Accident Form

Patient Name _____ **Today's Date** ____/____/_____

Please mark your involvement in the Auto Accident: ☐ Pedestrian ☐ Driver ☐ Passenger

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Date of Accident ____/____/_____

Patient was located: ☐ Driver ☐ Passenger- middle front ☐ Passenger- right front
☐ Passenger- left rear ☐ Passenger- middle rear ☐ Passenger -right rear

Patient Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Second Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Third Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Road Conditions: ☐ Clear ☐ Dark ☐ Dry ☐ Foggy ☐ Icy ☐ Wet

Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐ Gravel

Were you aware the accident was going to occur? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Did your airbag deploy? ☐ Yes ☐ No

Does your car have a head rest? ☐ Yes ☐ No

What position was the head rest in? ☐ Up ☐ Middle ☐ Down

Patient's Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Accident Details

Was your car braking? ☐ Yes ☐ No **Was your car moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the second vehicle braking? ☐ Yes ☐ No **Was the second vehicle moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the third vehicle braking? ☐ Yes ☐ No **Was the third vehicle moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Collision Details

First Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left
☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top

Second Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left
☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top

Collision Results

Body was thrown: ☐ Forward ☐ Backward ☐ Left ☐ Right ☐ Can't Remember

Head Hit: ☐ airbag ☐ front windshield ☐ rearview mirror ☐ steering wheel
☐ dashboard ☐ back of the front seat ☐ side window/door ☐ another person's body ☐ headrest

Chest Hit: ☐ airbag ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ side window/door ☐ another person's body

Shoulders Hit: ☐ shoulder harness ☐ side window/door ☐ back of front seat ☐ another person's body

Knees Hit: ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ door panel ☐ center console ☐ another person's body

Hips Hit: ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ door panel ☐ center console ☐ another person's body

Vehicle Damage

Patient Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage
Second Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage
Third Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage

Hospitalized

Were you hospitalized? ☐ Yes ☐ No. If yes, please answer the questions below.

When were you hospitalized? ☐ immediately ☐ later same day ☐ next day ☐ date _____

How were you transported to the hospital? ☐ ambulance ☐ life flight ☐ private transportation

What did the hospital recommend? ☐ no instructions ☐ see this clinic ☐ see DC
☐ see own doctor ☐ see orthopedist ☐ see neurologist ☐ prescription medication
☐ other: _____

Did you have any xrays taken? ☐ Yes ☐ No
If yes, what areas? _____

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Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ **Case:** _____ **Date:** _____
Dr: _____
Chief Complaint: _____

HT. _____ **WT.** _____ **B/P** _____ **Pulse** _____

Body Area(s) Involved: ☐ Cervical ☐ Spine, Ribs, Pelvis ☐ Upper Extremity ☐ Lower Extremity

Condition: ☐ New (less than 6 wks) ☐ Chronic (more than 6 wks) ☐ Recurrence ☐ Exacerbation

Mechanism of Onset:
☐ Auto: (see auto accident history form)
☐ Work: ☐ Fall ☐ Lifting ☐ Overexertion ☐ Repetitive Motion ☐ Other: (see accident history form)
☐ Other: ☐ Etiology Unknown ☐ Overexertion ☐ Repetitive Use ☐ Slept Wrong ☐ Slip or Fall
☐ No Injury

Description of Onset of Complaint: _____

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: Left / Right / Bilateral _____

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other _____

Level of Impairment Due to Symptoms (Resting):
0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):
0 1 2 3 4 5 6 7 8 9 10

Duration: Started: _____
Last Occurred: _____ Last episode: _____ Resolved Previous Visit: _____
Worsened: _____ Injury Occurred: _____ Accident Occurred: _____
Timing: *Worse*: ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Intermittent
Context: *Better with:* ☐ Warm Temp ☐ Cold Temp *Worse with:* ☐ Warm Temp ☐ Cold Temp ☐ Damp

Assoc Signs and Symptoms: ☐ Blurred Vision ☐ Depression ☐ Dizziness ☐ Irritability/Mood Swing
☐ Localized Tingling ☐ Nausea ☐ Ringing in Ears ☐ Sleep Disturbance ☐ Stiffness

Headaches: Location: ☐ Occipital ☐ Frontal ☐ Left Temporal ☐ Right Temporal ☐ Parietal ☐ Sinus
Quality: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Stabbing ☐ Aura ☐ No Aura
Types: ☐ Hat Band ☐ Cluster ☐ Migraine ☐ Tension
Other: (frequency/duration/time of day) _____

Radiation: Left / Right / Bilateral _____
Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms:

☐ aches	☐ burning	☐ cold limb(s)	☐ difficulty walking	☐ dizziness
☐ ecchymosis	☐ chronic fatigue	☐ fever	☐ heartburn	☐ joint stiffness
☐ muscle spasm	☐ muscle weakness	☐ nausea	☐ numbness	☐ pale bluish skin
☐ panic	☐ pins & needles	☐ rhinorrhea (runny nose)	☐ shortness of breath	☐ sweating
☐ swelling	☐ tingling	☐ vomiting		

Modifying Factors:

Symptoms Better With: ☐ nothing helps ☐ activity ☐ bending ☐ applying cold ☐ applying heat
☐ massage ☐ movement ☐ OTC meds ☐ Rx meds ☐ rest
☐ stretching ☐ sitting ☐ standing ☐ twisting ☐ walking

Symptoms Worse With: (as noted in Social History)

Since condition began, has anything permanently helped you? ☐ YES ☐ NO

Has anything that you have done, thus far, fixed you problem? ☐ YES ☐ NO

Employment

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description of Work: _____

Job Classification: ☐ Sedentary (<5lbs) ☐ Light (5-20lbs) ☐ Moderate (20-50lbs) ☐ Heavy (>50 lbs)

Lifting Frequency: ☐ Constant (67-100%/day) ☐ Frequent (33-66%/day) ☐ Occasional (0-32%/day)

Lifting Postures: ☐ with Arms ☐ High Near ☐ from Knee ☐ off Posture ☐ from Torso

Work Activity Postures: (hrs/day)

☐ bending: _____h/d ☐ climbing: _____h/d ☐ kneeling: _____h/d ☐ pulling: _____h/d ☐ pushing: _____h/d
☐ reaching: _____h/d ☐ sitting: _____h/d ☐ standing: _____h/d ☐ twisting: _____h/d ☐ walking: _____h/d

Repetitive Activities: (hrs/day)

☐ assembly/fine manipulation: _____h/d ☐ computer use/typing: _____ h/d ☐ grasping: _____ h/d
☐ hand tool use: _____ h/d ☐ operation of machinery controls: _____ h/d ☐ phone use: _____h/d

Condition's Effect on Job Performance:

☐ Mild Painful (Can do) ☐ Mod Painful (limited ability)
☐ Mod/Sev Limited Duty ☐ Sev No Limited Duty ☐ Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Care--Infirm Family:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Carrying Groceries:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Change Posn--Sit-Stand:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Extended Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Feeding:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Lift Children:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Pet Care:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Self Care:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Self Care--Bathing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Self Care--Dressing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Self Care--Shaving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Sexual Activities:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Static Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Static Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Yard Work:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ chills ☐ fatigue ☐ night sweats ☐ weight loss
☐ daytime drowsiness ☐ fever ☐ weight gain

Eyes/Vision: ☐ I DENY having any of the symptoms or problems listed below.

☐ blindness ☐ change in vision ☐ field cuts ☐ photophobia
☐ blurred vision ☐ double vision ☐ glaucoma ☐ tearing
☐ cataracts ☐ eye pain ☐ itching ☐ wear glasses/contacts

Ears, Nose and Throat: ☐ I DENY having any of the symptoms or problems listed below.

☐ bleeding ☐ ear drainage ☐ hearing loss ☐ nosebleeds ☐ sore throat
☐ dentures ☐ ear pain ☐ history of head injury ☐ postnasal drip ☐ tinnitus (ringing in ears)
☐ difficulty swallowing ☐ fainting ☐ hoarseness ☐ rhinorrhea (runny nose) ☐ TMJ problems
☐ discharge ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infections
☐ dizziness ☐ headaches ☐ nasal congestion ☐ snoring

Respiration: ☐ I DENY having any of the symptoms or problems listed below.

☐ asthma ☐ coughing up blood ☐ sputum production
☐ cough ☐ shortness of breath ☐ wheezing

Cardiovascular: ☐ I DENY having any of the symptoms or problems listed below.

☐ angina (chest pain or discomfort) ☐ high blood pressure ☐ shortness of breath with exertion or exercise
☐ chest pain ☐ low blood pressure ☐ swelling of legs
☐ claudication (leg pain/ache) ☐ orthopnea (difficulty breathing lying down) ☐ ulcers
☐ heart murmur ☐ palpitations ☐ varicose veins
☐ heart problems ☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

Gastrointestinal: ☐ I DENY having any of the symptoms or problems listed below.

☐ abdominal pain ☐ diarrhea ☐ indigestion ☐ abnormal stool caliber ☐ vomiting blood
☐ belching ☐ difficulty swallowing ☐ jaundice ☐ abnormal stool color
☐ black - tarry stools ☐ heartburn ☐ nausea ☐ abnormal stool consistency
☐ constipation ☐ hemorrhoids ☐ rectal bleeding ☐ vomiting

Female: ☐ I DENY having any of the symptoms/problems and/or using any of the items listed below.

☐ birth control ☐ cramps ☐ irregular menstruation ☐ vaginal bleeding
☐ breast lumps/pain ☐ frequent urination ☐ pregnancy ☐ vaginal discharge
☐ burning urination ☐ hormone therapy ☐ urine retention

Male: ☐ I DENY having any of the symptoms or problems listed below.

☐ burning urination ☐ frequent urination ☐ prostate problems
☐ erectile dysfunction ☐ hesitancy/ dribbling ☐ urine retention

Endocrine: ☐ I DENY having any of the symptoms or problems listed below.

☐ cold intolerance ☐ excessive hunger ☐ goiter ☐ unusual hair growth
☐ diabetes ☐ excessive thirst ☐ hair loss ☐ voice changes
☐ excessive appetite ☐ abnormal frequency of urination ☐ heat intolerance

Skin: ☐ I DENY having any of the symptoms or problems listed below.

☐ changes in nail texture ☐ hair loss ☐ itching ☐ skin lesions / ulcers
☐ changes in skin color ☐ hives ☐ paresthesias ☐ varicosities
☐ hair growth ☐ history of skin disorders ☐ rash

Nervous System: ☐ I DENY having any of the symptoms or problems listed below.

☐ dizziness ☐ limb weakness ☐ numbness ☐ slurred speech ☐ tremor
☐ facial weakness ☐ loss of consciousness ☐ seizures ☐ stress ☐ unsteadiness of gait/ loss of balance
☐ headache ☐ loss of memory ☐ sleep disturbance ☐ strokes

Psychologic: ☐ I DENY having any of the symptoms or problems listed below.

☐ anhedonia ☐ behavioral change ☐ convulsions ☐ memory loss
☐ anxiety ☐ bi-polar disorder ☐ depression ☐ mood change
☐ loss or change in appetite ☐ confusion ☐ insomnia

Allergy: ☐ I DENY having any of the symptoms or problems listed below.

☐ anaphalaxis ☐ itching ☐ chronic nasal congestion ☐ sneezing
☐ food intolerance ☐ acute nasal congestion ☐ rash

Hematologic: ☐ I DENY having any of the symptoms or problems listed below.

☐ anemia ☐ blood clotting ☐ bruising easily ☐ lymph node swelling
☐ bleeding ☐ blood transfusion ☐ fatigue