POMPANO BEACH CHIROPRACTIC CLINIC, P.A.
Family practice since 1951!

4 NE 4th Avenue
Pompano Beach, FL 33060
(954) 943-1044 office
(954) 943-1014 fax
www.pompanochiro.com

ACCIDENT HISTORY REPORT

Claim #:_____ Patient ID #_____

Name: _____ Date: _____/_____/_____

Date of Accident: _____/_____/_____ Time of Accident:_____ AM / PM

Were you the: O Driver O Rear passenger O Front passenger O Pedestrian How many people were in the car? _____

Who owns the car? _____ Year & Model of your car: _____

Was your vehicle equipped with airbags? O Yes O No If yes, did they go off? O Yes O No

Year & Model of other car: _____ What was the approximate damage done to your car? $_____._____

Visibility at time of accident: O Poor O Fair O Good O Other: _____

Road conditions at time of accident: O Icy O Rainy O wet O Clear O Dark O Other: _____

Where were you struck and describe the accident in your own words: _____

_____

Did any part of your body strike anything in the vehicle? OYes O No If yes, please explain_____

Did you see the accident coming? O Yes O No Did you brace for impact? O Yes O No Were seatbelts worn? O Yes O No

Did your seat have a headrest? O Yes O No If yes, what was the position of the headrest? O Low O Midposition O High

Was your car braking? O Yes O No Was your car moving at the time of accident? O Yes O No If yes, how fast would you estimate you were going? _____mph How fast would you estimate the other car was going? _____mph

Head/Body position at the time of impact: O Head turned left/right O Head looking back O Head straight forward O Body straight in sitting position O Body rotated left/right O Other: _____

As a result of the accident you were: O Rendered unconscious O In shock O Dazed, circumstances vague O Other: _____

Could you move all parts of your body? O Yes O No If no, what parts couldn't you move and why?_____

Were you able to get out of the car and walk unaided? OYes O No If no, why not?_____

Did you experience any bleeding cuts? O Yes O No If yes, where? _____

Did you experience bruising? O Yes O No If yes, where? _____

Please describe how you felt: Immediately after the accident: _____
Later that day: _____
The next day: _____

Check symptoms apparent since the accident:

O Headache	O Neck pain/stiffness	O Mid back pain	O Eyes Light Sensitive
O Pain behind eyes	O Dizziness	O Fainting	O Sleeping problems
O Numbness in fingers	O Numbness in toes	O Loss of smell	O Loss of taste
O Loss of memory	O Fatigue	O Breath shortness	O Irritability
O Depression	O Ringing/Buzzing	O Loss of balance	O Tension
O Cold hands	O Cold feet	O Diarrhea	O Constipation
O Chest pain	O Nervousness	O Anxious	O Clicking or popping Jaw
O Low back pain	O Other: _____		

_____

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ACCIDENT REPORT HISTORY CONTINUED

Patient name:_____ Patient ID #_____

Occupation: _____ Employer: _____

Have you missed time from work: O Yes O No
If yes, full time off work: _____ to _____ Part time off work: _____ to _____

Did you go to the hospital? O Yes O No
When did you go? O Immediately after accident O Next day O 2 days or more after accident Date: _____/_____/_____
How did you get to the hospital? O Ambulance O Private Transportation
Name of Hospital: _____ Name of doctor: _____

Where you examined? O Yes On Were you x-rayed? O Yes O No Did you receive treatment? O Yes O No

If yes, what kind of treatment did you receive? _____

Did you receive? O Braces O Collars O Medications If so, please list: _____

What benefits did you receive from the treatment? _____

Date of last treatment? _____

Do you have an attorney on this claim? O Yes O No If yes, who? _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Illustrate below how the accident happened

Past Medical History: Place an (X) if it applies and describe.

O Hospital or operation O Auto Accident O Work Accident O Illness O None related to current complaints O Other

Describe: _____

_____

Family History: Place an (X) if any family member has suffered from:

O Tuberculosis	O Kidney Disease	O Spinal Disorder	O Mental Illness	O Epilepsy	O Diabetes
O Gout	O Allergy	O Arthritis	O Hypertension	O Cancer	O Heart Attack

O Other, list: _____

_____

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ACCIDENT REPORT HISTORY CONTINUED

Patient name:_____ Patient ID #_____

Personal History:

Medication Use/Chemical Stress Drugs taken in the last year and for what condition?

O Pain killers _____ O Birth control pills _____ O Antibiotics _____

O Blood Pressure _____ O Thyroid _____ O Other _____

Did/Do you smoke? Years _____ Packs/day_____ Do you drink alcohol? Amount _____

Disease, describe: _____

Other, describe: _____

System Review: Place an (X) next to the symptoms you know you have.

Genitourinary System: O Bladder trouble O Painful urination O Excessive urination O Discolored urine O Scanty urination

Gastro-Intestinal System: O Poor appetite O Vomiting food O Nausea O Constipation O Hemorrhoids
O Weight trouble O Liver trouble O Excessive hunger O Excessive thirst O Abdominal pain O Difficult swallowing
O Diarrhea O Bloody stool O Gallbladder trouble

Nervous System: O Numbness O Dizziness O Muscle jerking O Confusion O Loss of sleep O Fainting
O Convulsions O Depression O Paralysis O Headaches O Forgetfulness

Cardio-Vascular System: O Chest pain O Persistent Cough O Rapid heartbeat O Lung problems O Pain over heart
O Coughing phlegm O High Blood Pressure O Varicose veins O Difficult breathing O Coughing blood
O Heart problems O Other: _____

Eye, Ear, Nose and Throat System: O Eye Strain O Ear pain O Hearing loss O Nose discharge O Sore mouth
O Speech difficulty O Ear noises O Nose pain O Ear discharge O Sore gums O Nose bleeding
O Dental problems O Sore throat O Vision problems
O Breathing difficulty O Hoarseness O Eye inflammation

Current Chief Complaint(s): Place an (X) in the appropriate complaint areas. Next to each complaint place a number between 1-10 corresponding to your pain level. 1 = low pain 4-5 = moderate pain 7-9 = intense pain 10 = emergency

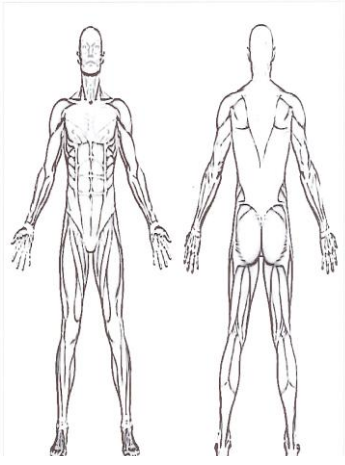
SPINE:
O Low Back _____ O Mid Back _____
O Pelvis _____ O Neck _____

UPPER EXTREMITY:
O Shoulder L/R _____ O Forearm L/R _____
O Wrist L R _____ O Elbow L/R_____
O Arm L /R _____ O Hand L/ R_____

LOWER EXTREMITY:
O Hip L/R _____ O Ankle L/R _____
O Leg L/R _____ O Knee L/R _____
O Thigh L/R _____ O Foot L/ R _____

OTHER (describe): _____

_____



Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X Numbness O Pins & Needles

+ Burning = Stabbing

I certify that above information is correct to the best of my knowledge.

Patient Signature _____ ***Date*** _____