

# MOTOR VEHICLE ACCIDENT HISTORY

|   |   |   |   |
|---|---|---|---|
| PATIENT NAME:   |   | DATE:   |   |
| ADDRESS:  |   | CITY:   | STATE/ZIP CODE:   |
| HOME PHONE NUMBER:  |   | CELL PHONE NUMBER:  |   |
| SOCIAL SECURITY NUMBER:   | DATE OF BIRTH:  | AGE:  | GENDER:   |
| EMERGENCY CONTACT NAME:   |   | EMERGENCY CONTACT PHONE NUMBER:   |   |
| EMPLOYER NAME:  |   | EMPLOYER ADDRESS:   |   |
| <b>ACCIDENT INFORMATION</b>   |   |   |   |
| DATE OF ACCIDENT:   | TIME OF ACCIDENT:   | WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT?<br><input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> FRONT SEAT <input type="checkbox"/> BACK SEAT |   |
| NUMBER OF PEOPLE IN THE CAR:  | NAMES OF PEOPLE IN THE CAR WITH YOU:  |   |   |
| WHAT DIRECTION WAS YOUR CAR HEADED?<br><input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST      |   | ON WHAT STREET WERE YOU HEADED?   |   |
| WHAT DIRECTION WAS THE OTHER CAR HEADED?<br><input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST |   | WERE YOU STRUCK FROM:<br><input type="checkbox"/> BEHIND <input type="checkbox"/> FRONT <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE  |   |
| Please describe your accident.  |   | Drawing of incident.  |   |
| WERE YOU KNOCKED UNCONSCIOUS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |   | DID YOU HIT YOUR HEAD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |   |
| WHERE WERE YOU TAKEN AFTER THE ACCIDENT?  |   |   | BY AMBULANCE:<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| WERE THE POLICE ON THE SCENE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | WAS A REPORT FILED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | DO YOU HAVE A COPY?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |   |
| HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS INJURY/ ACCIDENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                     | SINCE THE INJURY, ARE YOUR SYMPTOMS:<br><input type="checkbox"/> IMPROVING <input type="checkbox"/> GETTING WORSE <input type="checkbox"/> GETTING BETTER |   |   |
| HAVE YOU LOST TIME FROM WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | DATE YOU LEFT WORK:   | DATE YOU RETURNED TO WORK:  |   |

**Cedar Chiropractic**  
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|---|--------------------------|
| HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST?<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO                | IF YES, PLEASE DESCRIBE: |
| DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE?<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO     | IF YES, PLEASE DESCRIBE: |
| DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY?<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO | IF YES, PLEASE DESCRIBE: |

**INSURANCE INFORMATION**

AUTO INSURANCE COMPANY NAME:

ADJUSTER NAME:

ADJUSTER PHONE NUMBER:

POLICY NUMBER:

CLAIM NUMBER:

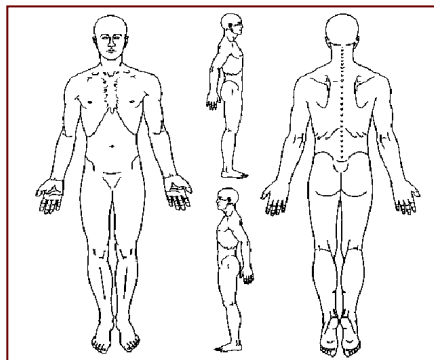
**SYMPTOMS**

INSTRUCTIONS: Check (✓)any/all symptoms noted after the accident.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> HEADACHE          | <input type="checkbox"/> DIZZINESS              | <input type="checkbox"/> LIGHT BOTHERS EYES |
| <input type="checkbox"/> NECK PAIN         | <input type="checkbox"/> HEAD SEEMS HEAVY       | <input type="checkbox"/> LOSS OF MEMORY     |
| <input type="checkbox"/> NECK STIFFNESS    | <input type="checkbox"/> PINS & NEEDLES IN ARMS | <input type="checkbox"/> EARS RING          |
| <input type="checkbox"/> SLEEPING PROBLEMS | <input type="checkbox"/> PINS & NEEDLES IN LEGS | <input type="checkbox"/> FACE FLUSHED       |
| <input type="checkbox"/> BACK PAIN         | <input type="checkbox"/> NUMBNESS IN FINGERS    | <input type="checkbox"/> BUZZING IN EARS    |
| <input type="checkbox"/> NERVOUSNESS       | <input type="checkbox"/> NUMBNESS IN TOES       | <input type="checkbox"/> LOSS OF BALANCE    |
| <input type="checkbox"/> TENSION           | <input type="checkbox"/> SHORTNESS OF BREATH    | <input type="checkbox"/> FAINTING           |
| <input type="checkbox"/> IRRITABILITY      | <input type="checkbox"/> FATIGUE                | <input type="checkbox"/> LOSS OF SMELL      |
| <input type="checkbox"/> CHEST PAIN        | <input type="checkbox"/> DEPRESSION             | <input type="checkbox"/> LOSS OF TASTE      |
| <input type="checkbox"/> DIARRHEA          | <input type="checkbox"/> FEET FEEL COLD         | <input type="checkbox"/> UPSET STOMACH      |
| <input type="checkbox"/> CONSTIPATION      | <input type="checkbox"/> HANDS FEEL COLD        | <input type="checkbox"/> OTHER: _____       |
| <input type="checkbox"/> FEVER             | <input type="checkbox"/> COLD SWEATS            | <input type="checkbox"/> OTHER: _____       |

INSTRUCTIONS: Please mark the area and type of pain on the drawings using the codes listed below:

N=Numbness    P=Pain    A=Ache    T=Tingling    S=Stiffness/Soreness



COMMENTS:

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PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

Patient Signature:

Date: