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:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? ❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT	
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:		
WHAT DIRECTION WAS YOUR CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		ON WHAT STEET WERE YOU HEADED?	
WHAT DIRECTION WAS THE OTHER CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		WERE YOU STRUCK FROM: ❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE	
Please describe your accident.		Drawing of incident.	
WERE YOU KNOCKED UNCONSCIOUS? ❑ YES ❑ NO		DID YOU HIT YOUR HEAD? ❑ YES ❑ NO	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?			BY AMBULANCE: ❑ YES ❑ NO
WERE THE POLICE ON THE SCENE? ❑ YES ❑ NO	WAS A REPORT FILED? ❑ YES ❑ NO	DO YOU HAVE A COPY? ❑ YES ❑ NO	
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS INJURY/ ACCIDENT? ❑ YES ❑ NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: ❑ STAYED THE SAME ❑ GETTING WORSE ❑ GETTING BETTER	
HAVE YOU LOST TIME FROM WORK? ❑ YES ❑ NO		DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK:

Cedar Chiropractic
130 26th St. NW
Owatonna, MN 55060

HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? ❑ YES ❑ NO	IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? ❑ YES ❑ NO	IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ❑ YES ❑ NO	IF YES, PLEASE DESCRIBE:

INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:

ADJUSTER NAME: ADJUSTER PHONE NUMBER:

POLICY NUMBER: CLAIM NUMBER:

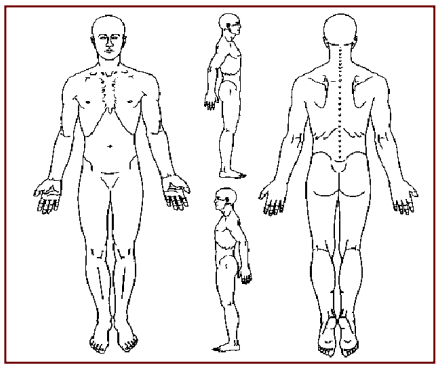
SYMPTOMS

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

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

INTRUCTIONS: *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: