ribley family chiropractic

# Motor Vehicle Accident Information

| Patient Name : | Social Security #.: |
|---|---|
| Date of Accident: | |
| ☐I was the driver<br>☐I was the passenger seated in the ☐front ☐rear left ☐rear middle ☐rear right | |

| | | |
|---|---|---|
| Patients Vehicle: | Type: | ☐Car ☐Van ☐Truck ☐Bus ☐SUV ☐Motor Cycle |
| | Size: | ☐Mini ☐Sub Comp ☐Compact ☐Mid Size ☐Full Size |
| | Action: | ☐Stopped ☐Slowing ☐Acceleration ☐Cruising |
| | Speed: | approximately MPH |
| | Time: | ☐Day Light ☐Dawn ☐ Dusk ☐Dark |
| | Road Condition: | ☐Dry ☐Damp ☐Wet ☐Snow ☐Ice |
| | Visibility: | ☐Good ☐Fair ☐Poor |

*Enter impact Information for up to three Vehicles or Objects*

Impact Information: Vehicle or Object (I)

| | | |
|---|---|---|
| Collision with a | Name Object : | |
| ☐ Vehicle | Vehicle Type : | ☐Car ☐Van ☐Pickup ☐Truck ☐Bus ☐SUV ☐M. Cycle |
| | Size : | ☐Mini ☐Sub Comp ☐Compact ☐Mid Size ☐Full Size |
| ☐ Object | Car Damage: | ☐Minimal ☐Moderate ☐Extensive ☐Totaled ☐Unsure |

Impact Information: Vehicle or Object (II)

| | | |
|---|---|---|
| Collision with a | Name Object : | |
| ☐ Vehicle | Vehicle Type : | ☐Car ☐Van ☐Pickup ☐Truck ☐Bus ☐SUV ☐M. Cycle |
| | Size : | ☐Mini ☐Sub Comp ☐Compact ☐Mid Size ☐Full Size |
| ☐ Object | Car Damage: | ☐Minimal ☐Moderate ☐Extensive ☐Totaled ☐Unsure |

Impact Information: Vehicle or Object (III)

| | | |
|---|---|---|
| Collision with a | Name Object : | |
| ☐ Vehicle | Vehicle Type : | ☐Car ☐Van ☐Pickup ☐Truck ☐Bus ☐SUV ☐M. Cycle |
| | Size : | ☐Mini ☐Sub Comp ☐Compact ☐Mid Size ☐Full Size |
| ☐ Object | Car Damage: | ☐Minimal ☐Moderate ☐Extensive ☐Totaled ☐Unsure |

## During Impact Information:

| | | | | | |
|---|---|---|---|---|---|
| Seat Belt? | ☐ Yes | ☐ No | Brakes Applied ? | ☐ Yes | ☐ No |
| Air Bag Deployed? | ☐ Yes | ☐ No | Seat Broken ? | ☐ Yes | ☐ No |
| Seat Back position Changed? | ☐ Yes | ☐ No | | | |

| | |
|---|---|
| Head Rest: | Low / Mid / High / None |
| Impact was: | Un-expected / Expected / Expected and Braced |
| Body Position: | Straight / Rotated Left / Rotated Right / Unsure / Other: |
| Body Thrown? | ☐Yes / ☐No |
| Direction of Throw: | Backwards / Forward / Outside / Unsure / Other: |
| Head Position: | Straight / Rotated Left / Rotated Right / Forward / Unsure / Other: |
| Head Motion: | Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other: |

## Body Impact (Indicate any parts of your body that were struck during the impact)

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Upper Back | ☐ Right hand | ☐ Lower Back |
| ☐ Left Shoulder | ☐ Left Leg | ☐ Mid Torso | ☐ Right Foot |
| ☐ Left Arm | ☐ Right Leg | ☐ Mid Back | ☐ Left Foot |
| ☐ Left Elbow | ☐ Right Shoulder | ☐ Right Knee | ☐ Other : |
| ☐ Left hand | ☐ Right Arm | ☐ Left Knee | |
| ☐ Upper Front Torso | ☐ Right Elbow | ☐ Lower Front Torso | |

## After Accident Information:

| | |
|---|---|
| Immediately After Accident: | ☐Dizzy/dazed ☐Upset ☐Weak ☐Nervous ☐Headache ☐Disoriented ☐Unconscious ☐/Other: |

## Pain immediately after accident:

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Left foot | ☐ Right foot | ☐ Left Knee |
| ☐ Left Hand | ☐ Left Shoulder | ☐ Right Shoulder | ☐ Right knee |
| ☐ Right Arm | ☐ Left Elbow | ☐ Left Arm | ☐ Other : |
| ☐ Upper Front Torso | ☐ Mid Torso | ☐ Right elbow | |
| ☐ Upper Back | ☐ Mid back | ☐ Lower Front Torso | |
| ☐ Left Leg | ☐ Right Leg | ☐ Lower Back | |

## Numbness immediately after accident:

☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm
☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

## Medical Information (Did you get medical care for this accident before coming to our office)

| | |
|---|---|
| Medical Care? | ☐Yes ☐No |
| Time of care: | ☐Next day ☐At time of Accident ☐Later that Day ☐Days Later: (Specify) |
| Transportation: | ☐Drove Self ☐Ambulance ☐Other |
| Went To: | ☐Orthopedic ☐Chiropractor ☐Neurologist ☐Family Doc ☐ER ☐Other:(Specify) |
| Admitted to Hospital? | ☐Yes ☐No Days Spent in Hospital: |
| Test: | ☐X-ray ☐Lab Work ☐MRI ☐CT Scan ☐Other:(Specify) |
| Treatment: | ☐Ice Pack ☐Hot Pack ☐Cervical Collar ☐Medication ☐None ☐Other:(Specify) |

## Previous Injuries

| | |
|---|---|
| Previous Injuries / Accidents | ☐ No ☐ Yes, Specify: |
| Residual pain from Previous Injuries/Accidents | ☐ No ☐ Yes, Specify: |

## Later Symptoms (Please note any symptoms that started after the accident occurred)

| | |
|---|---|
| Head | ☐Headache ☐Dizziness ☐Blurred Vision ☐Light Headedness ☐Loss of Vision<br>☐Fainting ☐Loss of Memory ☐Pain in ear ☐Double Vision<br>☐Other Specify: |
| Neck (with Movement) | ☐Pain in Neck ☐Forward ☐Backward ☐Turn Left ☐Popping in Neck<br>☐Muscle Spasms ☐Turn Right ☐Bend Left ☐Bend Right<br>☐Other Specify: |
| Shoulders | ☐Pain in Shoulder joint ☐Tension in shoulders ☐Muscle Spasms in Shoulder<br>☐Pain across shoulder ☐Cant raise arms above [ ] Above shoulder level [ ] Over head<br>☐Other Specify: |
| Arms and Hands | ☐Pain in Fingers ☐Numbness in Left Arm ☐Hands Cold ☐Pin & needles in hands<br>☐Numbness in Right Arm ☐Loss of Grip Strength ☐Pin & needles in fingers<br>☐Swollen joints in Fingers ☐Other Specify: |
| Chest | ☐Chest pain ☐Pain Around Ribs ☐Shortness of Breadth ☐Breast Pain<br>☐Other Specify: |
| Abdomen | ☐Nervous Stomach ☐Nausea ☐Diarrhea ☐Gas ☐Constipation<br>☐Other Specify: |
| Mid back | ☐Sharp Stabbing ☐Mid pain back ☐Pain From front to back ☐Dull Ache<br>☐Pain in Kidney Area ☐Muscle Spasms ☐Pain between shoulders<br>☐Other Specify: |
| Lower Back | ☐Low Back Pain<br><br>Low back pain is worse when:<br>☐Working ☐Lifting ☐Stooping ☐Standing<br>☐Sitting ☐Bending ☐Coughing ☐Lying Down ☐Muscle Spasms<br>☐Other Specify: |
| Hips, Legs & Feet | ☐Pain in Buttocks ☐Pain and needles in Legs ☐Pain down leg ☐Pain in hip joint<br>☐Feet feel Cold ☐Swollen Feet ☐Numbness in Toes ☐Numbness of Leg ☐Knee pain<br>☐Leg cramps ☐Cramps in Feet |