Auto/Work Related Accident

Cornerstone Chiropractic Clinic-13470 N 83rd Ave, Ste 302 Peoria, AZ 85381 623-249-7141 Jessica J. Haug, DC

About You:

Name_____ Date_____
Date of Birth___/____/_____

Auto Related Accident

Date & Time of Accident_____ a.m./p.m.
Were you the: Driver/Front Passenger/Rear Passenger
If a traffic violation was issued, to whom was it issued?
_____
Number of people in accident vehicle?_____
Did the police come to the accident?..... Yes/ No
Was a police report filed?..... Yes/ No
Were there any witnesses?..... Yes/ No
Were you wearing your seat belt?..... Yes/ No
Was this vehicle equipped with airbags?..... Yes/ No
If yes, did it/they inflate?..... Yes/ No
In relation to the base of your skull, where was the headrest?..... Above/ Below/ At the base of skull
What did your vehicle impact?..... Another car/ Other
If other, please explain: _____
_____
_____
Did any part of your body strike anything in the vehicle?
Yes/ No If yes, please describe: _____
_____
_____
Make & model of the vehicle you were occupying:
_____
Name of the location/street on which you were traveling:
_____
In which direction were you headed?..... N/ S/ E/ W
What was the approx. speed of your vehicle? _____
Did the impact to your vehicle come from the: Front/Rear /Right Side/ Left Side/ Other
During impact, were you facing:……. Right/ Left/ Forward
Were you aware or surprised by the impact?_____
If accident vehicle make impact with another vehicle…
make & model of other vehicle: _____
_____
Direction other vehicle was headed?..... N/ S/ E/ W
Speed of the other vehicle? _____
In your own words, Please describe the accident: _____
_____
_____
_____
_____

Work Related Accident

Date & Time of Accident_____ a.m./p.m.
Was your accident directly related to your work?... Yes/ No
Briefly describe the events that occurred just before and during your accident: _____
_____
_____
Give the address where accident occurred: _____
_____
Was anyone else present during your accident?..... Yes/ No
Did you report your accident to your employer?..... Yes/ No
What recommendations did your employer make just after your accident? _____
_____
Has this type of accident happened to you before?.. Yes/ No
To the best of your knowledge, has this accident occurred in your workplace before?..... Yes/ No
In general:
Is your job physically stressful?..... Yes/ No
Is your job mentally stressful?..... Yes/ No
Is your workplace noisy?..... Yes/ No
Have you changed jobs in the last year?..... Yes/ No

After Injury

Did accident render you unconscious?..... Yes/ No
If yes, for how long? _____
Please describe how you felt immediately after the accident: _____
_____
_____
Have you gone to a hospital or seen another Doctor? .....Yes/No
When did you go?.. Just after accident/he next day/2+ days
How did you get there? Ambulance/Private Transportation
Name of Hospital or Attending doctor? _____
_____
Was s/he a:…….. D.C/ M.D/ D. O./ D.D.S.
Describe any treatment you received? _____
_____
Were X-rays taken?..... Yes/ No
Was medication prescribed?..... Yes/ No
Have you been able to work since this injury?..... Yes/ No
Are your work activities restricted as a result of this injury?..... Yes/ No
Indicate **[X]** the symptoms that are a result of this accident:

Dizziness _____	Memory Loss ___	Headache(s) ___
Blurred vision ____	Buzzing in ear ___	Ears ringing ___
Difficult sleeping ___	Irritability ___	Tension ___
Numb Hands/Fingers ___	Stiff Neck ___	Jaw problems ___
Arms/Shoulder Pain ___	Neck Pain___	Chest pain ___
Shortness of Breath ___	Nausea ___	Back Pain ___
Upset Stomach ___	Leg Stiffness ___	Lower Back pain ___
Back stiffness __	Numb Feet/Toes ___	Other_____

Is your condition getting worse? ....Yes/ No/ Comes & Goes

Indicate [X] your degree of comfort while performing the following activities:

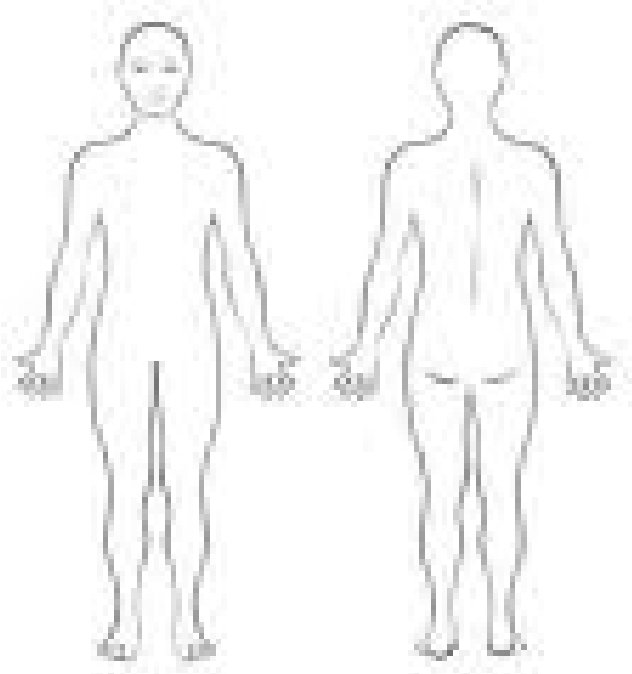
	Comfortable	Uncomfortable (even if only sometimes)	Painful
Lying on back	_____	_____	_____
Lying on side	_____	_____	_____
Lying on stomach	_____	_____	_____
Sitting	_____	_____	_____
Standing	_____	_____	_____
Stretching	_____	_____	_____
Lovemaking	_____	_____	_____
Walking	_____	_____	_____
Running	_____	_____	_____
Sports	_____	_____	_____
Working	_____	_____	_____
Lifting	_____	_____	_____
Bending	_____	_____	_____
Kneeling	_____	_____	_____
Pulling	_____	_____	_____
Reaching	_____	_____	_____

Have you retained an attorney? .....Yes/ No
If yes, whom:_____
His/Her phone #:_____

Where it Hurts

Please mark **area(s)** of injury or discomfort. Mark all areas with appropriate symbols and indicate the degree of pain using a **scale from 1-10**, 1 being discomfort and 10 being extreme pain.

Numbness **(NNNN)**
Burning **(BBBB)**
Stabbing **(SSSS)**
Pins & Needles **(PPPP)**
Aching **(AAAA)**



R ← Front→L L←Back→R

Recovery

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal work day? _____

Please indicate **[X]** your daily hob duties and any activities which you are occasionally asked to perform:

Standing_____	Driving _____	Operating Equipment_____
Sitting_____	Twisting_____	Work with arms above head_____
Walking _____	Crawling _____	Typing_____
Lifting_____	Bending_____	Stooping _____

Other_____
What positions can you work in with minimum physical effort and for how long?_____ N/A_____
Prior to the injury were you capable of working on an equal basis with others your age? .....Yes/ No/ N/A
Do you work with others who can help you with any heavy lifting?.....Yes/ No/ N/A
While in recovery, is there any light duty work you could request?..... Yes/ No/ N/A

Additional Insurance

(*2nd Insurance Source or Auto Insurance*)
Type of Insurance_____
Co. Name_____
Address_____
Phone #_____
Insured's Name_____
Policy #_____Claim#_____
Insured's SS #_____ D.O.B.__/____/_____
Insured's Employer_____
Agent's Name_____