Oldsmar Chiropractic Center
(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS…THANK YOU!)

Last Name_____ First Name _____ Middle _____
Home Phone_____ Work Phone _____
Street Address and Number_____
Mailing Address if Different_____
City, State, and Zip Code: _____
Age:_____ Date of Birth_____ Social Security #_____-_____-_____: E-mail:_____
Sex: **MALE FEMALE** # of Children_____ Married _____ Single_____ Widowed_____ Divorced_____
Occupation_____ Employer_____
Drivers License # _____ State _____
In Case of Emergency, Please contact: Name_____ Phone _____
Do you have an attorney representing you for your accident: **YES**_____ **NO** _____ **Who?**_____

## CHIEF COMPLAINT:

Please number your symptoms (1 is the most severe) that you have developed since the accident.

| | | | |
|---|---|---|---|
| ___ Headaches | ___ Numbness in feet **R / L Both** | ___ Loss of Memory | ___ Pain Behind Eyes |
| ___ Neck Pain/Stiffness | ___ Arm Weakness **R/L Both** | ___ Dizziness | ___ Jaw Popping |
| ___ Leg Weakness **R/L Both** | ___ Mid Back Pain | ___ Sleeping Problems | ___ Numbness in fingers |
| ___ Facial Pain | ___ Low Back Pain | ___ Eyes Light Sensitive | ___ Fainting |
| ___ Irritability | ___ Arm Pain **R / L Both** | ___ Fatigue | ___ Breath Shortness |
| ___ Loss of Balance | ___ Leg Pain **R / L Both** | ___ Depression | ___ Ringing/Buzzing |
| ___ Cold Feet | ___ Muscle Spasm/Cramping | ___ Cold hands | ___ Chest Pain |
| ___ Shoulder **L or R Both** | ___ Diarrhea | ___ Constipation | Other_____ |

Which of these symptoms did you have before the Crash?#____ #____ #____ Are they Worse? **Yes No**

## HISTORY:

1. What was the Date of the Accident? _____ Time: _____ AM/PM
2. Were you the Driver ☐ **or** Passenger ☐ **or** Pedestrian ☐
3. If you were the **passenger** where were you sitting: **FRONT, BACK DRIVER SIDE, BACK PASSENGER SIDE**
4. Cars involved in accident Year, Type, Model, and Estimated speed.
   - **Your Car** Year _____ Type _____ Model _____ Speed _____
   - **Other Car** Year _____ Type _____ Model _____ Speed _____
   - **Other Car** Year _____ Type _____ Model _____ Speed _____
6. Type of Accident: ☐ Head-on Collision ☐ Broad-side Collision ☐ Front Impact ☐ Rear-end car in front of you ☐ Rear Impact ☐ Non-collision
7. Please describe the accident in your own words! (Be very specific!!) _____
8. Head/Body position at time of impact:
   - ☐ Head turned left ☐ Head turned right ☐ Body straight in sitting position
   - ☐ Head looking back ☐ Body rotated right ☐ Body rotated left
   - ☐ Head straight forward ☐ Other: _____
9. Were you wearing your seat belt? ☐ YES ☐ NO
10. Did you see the accident coming? ☐ YES ☐ NO
11. Did you brace yourself for impact? ☐ YES ☐ NO
12. Upon impact, do you recall striking any objects inside of the car? ☐ Yes ☐ No
    If yes, what objects did you strike? _____
13. Since the accident, are conditions becoming: ☐ BETTER ☐ WORSE ☐ SAME
14. Describe your symptoms: ☐ CONSTANT ☐ COMES & GOES
15. Please describe what symptoms you felt:
    - Immediately after the accident: _____
    - Later that day: _____
    - The next day: _____
16. Have your symptoms persisted since the point of impact ? ☐ Yes ☐ No
17. Did the EMS arrive at the scene? ☐ Yes ☐ No
    If yes, were you treated by them? ☐ Yes ☐ No
    Did the EMS take you to the hospital? ☐ Yes ☐ No ☐ Other: _____

18. Who was the 1st Doctor that treated you?
Name: _____
Date seen: _____
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No Were you: ☐ Sitting or ☐ Standing
Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
19. What relieves your symptoms? _____
20. What aggravates your symptoms? _____
21. Road conditions at time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark ☐ Other (describe): _____
22. Visibility at the time of the accident? ☐ Poor ☐ Fair ☐ Good ☐ Other: _____
23. Where was your car struck? _____
24. Were you wearing a hat or glasses? ☐ Yes ☐ No
If yes, where were they located after the accident? _____
25. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
26. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
27. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other: _____
28. Do you have an attorney representing you for this claim? ☐ Yes ☐ No
If yes, who? _____

## PAST MEDICAL HISTORY:

29. Do you have any prior history of any of the symptoms you checked above? ☐ Yes ☐ No If yes explain: _____
30. Have you ever had any prior automobile accidents or ever had any serious falls/injuries? If yes, please give dates and treatments:
31. What Medications are you currently taking? _____
Taken in last 6 months? _____
32. Have you ever had any surgeries or been hospitalized overnight? If yes, please give details: _____
33. Are you currently under the care of any other doctors for any Health related concerns? If yes, please describe. _____
34. Have you ever seen a Chiropractor before? If yes, then who, where & what treated for? _____

## FAMILY HISTORY:

35. Place a (X) if any family member has suffered from:

| | | |
|---|---|---|
| ☐ Tuberculosis | ☐ Kidney Disease | ☐ Spinal Disorder |
| ☐ Mental Illness | ☐ Epilepsy | ☐ Diabetes |
| ☐ Gout | ☐ Allergy | ☐ Arthritis |
| ☐ High Blood Pressure | ☐ Cancer | ☐ Migraines |
| ☐ Heart Attacks | ☐ Other, list: _____ | |

36. Who is your family physician for regular check-ups? _____
Date last seen? _____ What treatment? _____

37. Are you pregnant? ☐ YES ☐ NO

SIGNATURE OF PATIENT: _____ DATE: _____

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