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**ENOS CHIROPRACTIC**
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# AUTOMOBILE ACCIDENT HISTORY FORM

Name: _____ Date: _____

Date of Accident: _____ Time of Accident: _____ am/pm

City of Accident: _____ Street: _____

Road conditions: ☐ wet ☐ dry ☐ icy ☐ other: _____

Was there an incident/police report? ☐ Yes ☐ No Were you taken to a hospital? ☐ Yes ☐ No

If "yes" what hospital were you taken to? _____

Address: _____ City: _____ Zip: _____

How did you get to the hospital? _____

What parts of your body were examined or x-rayed? _____

Where were you seated in the vehicle? ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Were you aware of the car about to hit you? ☐ Yes ☐ No

Did you lose consciousness (black out)? ☐ Yes ☐ No

Were you wearing your seatbelt? ☐ Yes ☐ No

If yes was it a lap seatbelt only? ☐ ***or*** was it a shoulder lap seatbelt? ☐ ***please check one***

What is your vehicle Year? _____ Make? _____ and Model _____

Was your car stopped at the time of the accident? ☐ Yes ☐ No

If "yes" then was the drivers foot also on the brake? ☐ Yes ☐ No

My vehicle was ☐ moving ☐ slowing down ☐ gaining speed at the time of the Accident?

Please describe to the best of your knowledge what happened during this accident.

_____

_____

_____

Did you have any bruises or cuts? ☐ Yes ☐ No If so where are/were they located? _____

_____

On what part of your vehicle were you hit? _____

Were you looking straight ahead or was your head turned? _____

Was there a lot of damage to your car? Please describe to the best of your knowledge. _____

_____

Was your car towed away? ☐ Yes ☐ No

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# PATIENT INJURY INFORMATION FORM

**NAME** _____ **DATE** _____

**DATE OF INJURY** _____

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**(CIRCLE A NUMBER)** **(9 TO 10 YOU ARE IN THE HOSPITAL)**

## NECK

PLEASE RATE YOUR PAIN A SCALE OF 1-10 & DESCRIBE IT AS BEST YOU CAN.

1 2 3 4 5 6 7 8 9 10
NO PAIN MILD MODERATE PAIN HORRIBLE EXCRUCIATING PAIN

THE PAIN IS

SHARP _____ BURNING _____ DULL ACHE _____ CONSTANT _____ OFF & ON _____

DOES THE PAIN WAKE YOU UP AT NIGHT? YES _____ NO _____

HEAD FEELS HEAVY _____

WHICH SIDE HURTS WORSE? RIGHT _____ LEFT _____ BOTH SIDES _____

WORSE IN THE MORNING _____ OR NIGHT _____

DOES THE PAIN SHOOT INTO THE SHOULDERS? YES _____ NO _____

## HEADACHES

PLEASE RATE YOUR PAIN A SCALE OF 1-10 & DESCRIBE IT AS BEST YOU CAN.

1 2 3 4 5 6 7 8 9 10
NO PAIN MILD MODERATE PAIN HORRIBLE EXCRUCIATING PAIN

IS THE PAIN ON THE

RIGHT _____ LEFT _____ ENTIRE HEAD _____ IS IT CONSTANT __ OFF & ON ____

IS IT THROBBING _____ STABBING _____ SHARP _____

DOES IT HAPPEN IN THE MORNING _____ DAY _____ NIGHT _____

**NAME** _____

## SHOULDERS

PLEASE RATE YOUR PAIN A SCALE OF 1-10 & DESCRIBE IT AS BEST YOU CAN.

1 NO PAIN 2 3 MILD 4 5 MODERATE PAIN 6 7 HORRIBLE 8 9 10 EXCRUCIATING PAIN

WHICH SIDE HURTS THE RIGHT _____ LEFT _____
IS IT CONSTANT _____ OFF & ON WORSE AT NIGHT _____ OR DAY

## MID BACK

PLEASE RATE YOUR PAIN A SCALE OF 1-10 & DESCRIBE IT AS BEST YOU CAN.

1 NO PAIN 2 3 MILD 4 5 MODERATE PAIN 6 7 HORRIBLE 8 9 10 EXCRUCIATING PAIN

IS THE PAIN ON THE RIGHT ___ LEFT _____ MIDDLE _____
IS IT SHARP ___ BURNING ___ OR A DULL ACHE ___
IS IT WORSE IN THE AM _____ PM _____ OR ALL DAY AND NIGHT _____
IS THE PAIN BURNING _____ STABBING _____ ACHEY _____
DOES IT WAKE YOU UP YES ___ OR NO _____

## LOW BACK

PLEASE RATE YOUR PAIN A SCALE OF 1-10 & DESCRIBE IT AS BEST YOU CAN.

1 NO PAIN 2 3 MILD 4 5 MODERATE PAIN 6 7 HORRIBLE 8 9 10 EXCRUCIATING PAIN

IS THE PAIN ON THE RIGHT ___ LEFT _____ MIDDLE _____
IS IT SHARP ___ BURNING ___ OR A DULL ACHE ___
IS IT WORSE IN THE AM _____ PM _____ OR ALL DAY AND NIGHT _____
IS THE PAIN BURNING _____ STABBING _____ ACHEY _____
DOES IT WAKE YOU UP YES ___ OR NO _____

## EXTREMITIES

PLEASE RATE YOUR PAIN A SCALE OF 1-10 & DESCRIBE IT AS BEST YOU CAN.

1 NO PAIN 2 3 MILD 4 5 MODERATE PAIN 6 7 HORRIBLE 8 9 10 EXCRUCIATING PAIN

_____
_____
_____

## ALLERGIES

_____
_____

**NAME** _____

SURGERIES IN THE LAST FIVE YEARS, PLEASE LIST WITH YEAR

_____
_____
_____
_____

MEDICATIONS PRESCRIBED OR TAKING FOR THIS INJURY

_____
_____
_____
_____

OTHER DOCTORS OR HOSPITAL SEEN FOR CURRENT INJURY

_____
_____
_____
_____

LIST THE DAILY ACTIVITIES YOU HAVE HAD TO STOP PERFORMING.
EXAMPLE: YARD WORK, LAUNDRY, PLAYING WITH CHILDREN, ETC.

_____
_____
_____
_____

DID YOU HAVE ANY PRIOR PAIN?

_____
_____
_____
_____