JOHNSON FAMILY CHIROPRACTIC

3227 N. Prospect Rd., Peoria, IL 61603 (309) 688-8773

AUTO ACCIDENT INJURY HISTORY FORM

Today's Date____________________ Date of Auto Injury______________________________

Patient's Name____

Address____ City_________________________

State______ Zip_____________ SS#________________________ Date of Birth_____________

Home Phone________________ Work Phone_________________ Cell Phone______________

Place of Employment____

Type of work ____

If not working, is it because of your injuries? Y N

Marital Status: M W S D Spouse name__________________________

Referred by____

Who is responsible for this account?____

Have you retained an attorney: Y N Name_______________________________

I authorize the release of any medical information necessary to process this claim.

Signed____Date_____________________________

I authorize payment of medical benefits to Dr. Kyle Johnson (Johnson Family Chiropractic) and understand that I am responsible for any charges not covered by my insurance company.

Signed____Date_____________________________

Past Medical History:

Have you been hospitalized in last 5 years? Y N Why?_________________________

____

Surgeries: (dates & residuals)____

____

Fractures: (dates & site)____

Serious Illness:____

Workers Comp. Injuries:____

Auto Accidents:____

Other Personal Injury____

Any prior history of current complaints: (what & when)___________________________________

____

Have you been treated by a chiropractor for any of the above? (name & which complaint)_____

____

Health problems other than this accident____

____

Medications other than for this accident____

____

Details of Crash:

Date of accident_________________ Time of accident______________(Circle) sunny cloudy

Were you (circle) Driver Front seat passenger Rear seat passenger Rear of van

Motorcycle passenger Other_____________________

If passenger, who was driving?____

Who else was in vehicle?____

Year, make & model of vehicle____

Estimate speed at time of impact________________

Vehicle was (circle) Stopped Slowing Accelerating Parked

Year, make & model of other vehicle(s)____

Road conditions: (circle) Dry Damp Wet Snow Ice Sleet

Head restraints: (circle) None Stationary Adjustable Up Down Don’t know

Did crash affect: Head restraint position? Y N Seat position? Y N

Were any seats broken? Y N Which_______________________________________

Wearing lap belt? Y N Wearing shoulder harness? Y N

Did Air Bags deploy? Y N Was anyone struck? Y N Who?____________________

Your body position at time of impact? Sitting normal Leaning forward Other____________

Your head position at time of impact? Forward Turned left Turned right Looking up

Looking down Other_______________________________

Your hand position at time of impact? One on wheel Two on wheel Not applicable

Brakes applied? Y N Were you aware of impending crash? Y N

Describe accident____

____

____

Diagram accident:

During the Crash:

Did you strike any parts of the vehicle? Y N Describe________________________

Did your vehicle strike any object after the crash? Y N Describe_________________

____

Were you wearing a hat or glasses? Y N Were they still on after the crash? Y N

Were you unconscious? Y N

Damage to your vehicle:__________________________ Estimate repairs $____________________

Damage to other vehicle(s)____

Were police at the scene? Y N Was a report filed? Y N

After the Crash:

Mark your symptoms: [ ]memory loss [ ]blurred vision [ ]light sensitivity

[ ]headache [ ]dizzy [ ]loss of sleep [ ]nausea [ ]confusion/disoriented

[ ]neck pain [ ]arms tingle/numb [ ]legs tingle/numb [ ]upper back pain

[ ]mid back pain [ ]low back pain [ ]leg pain [ ]muscle spasm [ ]chest pain

[ ]hoarseness [ ]difficulty swallowing

When did symptoms appear? [ ]immediately [ ]_____hrs later [ ]other_____________

Explain (if necessary)____

Where did you go after accident? [ ]hospital [ ]physician [ ]home [ ]work

How did you get there?____

Emergency Treatment:

Which hospital treated you?________________________ Attending Doctor_________________

X-rays taken: Y N What part of your body was x-rayed?_______________________

Was lab work done? Y N Blood tests Urine test Other___________________

What treatment was done? (Circle) Cervical Collar Ice Heat

Medication____

Follow up instructions____

If treated other than in Emergency Room, please continue:

Doctor_______________________________ Specialty______________________________

Dates seen________________ Treatment____

Did it help? Y N Tests done____

Were you referred to another doctor? Y N Who__________________________

ACTIVITIES OF DAILY LIVING

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	O	O	O	O	Grocery shopping	O	O	O	O
Rising from chair	O	O	O	O	Household chores	O	O	O	O
Standing	O	O	O	O	Lifting objects	O	O	O	O
Walking	O	O	O	O	Reaching overhead	O	O	O	O
Lying down	O	O	O	O	Showering or bathing	O	O	O	O
Bending over	O	O	O	O	Dressing myself	O	O	O	O
Turning over in bed	O	O	O	O	Reading	O	O	O	O
Using a computer	O	O	O	O	Getting to sleep	O	O	O	O
Getting in/out of car	O	O	O	O	Staying asleep	O	O	O	O
Driving a car	O	O	O	O	Concentrating	O	O	O	O
Caring for family	O	O	O	O	Exercising	O	O	O	O
Looking over shoulder	O	O	O	O	________________	O	O	O	O
Yard Work	O	O	O	O	________________	O	O	O	O