NEW SPINE CHIROPRACTIC
12766 SE Stark St, Plaza 125 C
Portland, OR 97233 phone: (503) 232-2933 Fax: (971) 271-7054

Date:_____. Ins./Claim Number:_____.

Patient Name:_____. Phone Number:_____.

Date of Birth:_____.Date of Injury:_____Time of Accident:_____.

Location of Accident:_____.

Description of Accident:_____.

_____.

_____.

_____.

Details of Accident:

Year, make, and model of your vehicle:_____.

Were you the: Driver, front passenger, or rear passenger? (drivers side, passenger side, middle?)_____.

_____.

What was the estimated speed of your vehicle at the time of the accident?_____.

What type of accident was it? Rear-end, side impact, frontal collision, or other?_____.

What is the year, make, and model of the other vehicle(s) involved:_____.

Estimated speed of the other vehicle?_____.

The road conditions were (dry, wet, rain, snow, ice, other) at the time of the accident?_____.

Does your vehicle have a (fixed or adjustable) headrest? What position was it in (low, middle, or top)?

Was your seatback broken? (yes no). Did the airbag deploy? (yes no). If yes, did it strike you?___.

Were you wearing a: (Shoulder to lap seatbelt, lap belt only, car seat, no seatbelt was used, other)?

At the time of impact was your head position: (facing forward, looking up, looking down, turned to the left/right, other)?_____.

At the time of impact was your torso/body facing: (forward, leaning back, leaning forward, turned to the left/right, other)?_____.

Were you aware of the impending collision? (yes no). Did you brace for the impact? (yes no)

Were your hands on the steering wheel at the time of impact? (yes no).____.

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Was your foot on the brake pedal at the time of impact? (yes no). Was it knocked off the pedal?_____.

Did the collision move your vehicle? (yes no). If yes, how far?_____Feet.

Were you wearing a hat, glasses, etc at the time of the accident? (yes no). Were they knocked off?___.

Did any part of your body strike any object inside of the car? Explain:_____.

Did you lose consciousness after the accident? (yes no). If yes for how long?_____.

Describe the damage to your vehicle:_____.

What is the dollar amount of damage estimated by the body shop?_____.

Describe the damage to the other vehicle(s) involved:_____.

Did the police respond to the accident? (yes no). Did they file a report? (yes no).

Have you filed a DMV accident report? (yes no).

Where did you go immediately after the accident and how did you get there?_____.

Did you go to the hospital? (yes no). Were you taken there by ambulance? (yes no).

What hospital did you go to?_____.

What was their diagnosis?_____.

Did they take X rays? If so, of what body parts?_____.

What other tests/exams did they perform on you?_____.

What medications did they give you?_____.

Symptoms from the accident:

Immediately after the accident were you (dizzy, nauseous, vomiting, confused, disoriented, dazed, other)?_____.

Did you feel pain immediately after the accident? (yes no). If yes describe_____.

_____.

If you did not feel pain immediately after the accident, how long did it take until you began to feel pain?

_____.

Where did you feel pain?_____.

Do you or did you have any cuts/bruises from the accident? (yes no). If yes, where?_____.

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Present Symptoms

Please use the following sections to describe your current areas of pain. Please list each part of your body that is in pain and answer the related questions accordingly. Examples of body parts are: headaches, neck pain, upper back pain, mid back pain, low back pain, hip pain, knee pain, ankle/foot pain, shoulder pain, elbow pain, wrist/hand pain, chest/rib pain, etc.

Painful Body Part #1: _____.

What makes your pain increase? _____.

What makes your pain decrease? _____.

Describe your pain (i.e. achy, dull, sharp, etc) _____.

Does your pain stay local or does it radiate to another area? _____.

Rate your current pain on a scale from 0 to 10, where 0 is no pain at all and 10 is the worst pain imaginable (circle a number): **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain ever.**

Is your pain getting: circle one (getting better, worse, or staying the same) with time? _____.

What percentage of your waking hours do you feel your pain? (0 – 100%) _____.

Does your pain vary throughout the day? (i.e. worse in the a.m./p.m.) or is your pain constant? Explain

_____.

Painful Body Part #2: _____.

What makes your pain increase? _____.

What makes your pain decrease? _____.

Describe your pain (i.e. achy, dull, sharp, etc) _____.

Does your pain stay local or does it radiate to another area? _____.

Rate your current pain on a scale from 0 to 10, where 0 is no pain at all and 10 is the worst pain imaginable (circle a number): **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain ever.**

Is your pain getting: circle one (getting better, worse, or staying the same) with time? _____.

What percentage of your waking hours do you feel your pain? (0 – 100%) _____.

Does your pain vary throughout the day? (i.e. worse in the a.m./p.m.) or is your pain constant? Explain

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Painful Body Part #3: _____.

What makes your pain increase? _____.

What makes your pain decrease? _____.

Describe your pain (i.e. achy, dull, sharp, etc) _____.

Does your pain stay local or does it radiate to another area? _____.

Rate your current pain on a scale from 0 to 10, where 0 is no pain at all and 10 is the worst pain imaginable (circle a number): **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain ever.**

Is your pain getting: circle one (getting better, worse, or staying the same) with time? _____.

What percentage of your waking hours do you feel your pain? (0 – 100%) _____.

Does your pain vary throughout the day? (i.e. worse in the a.m./p.m.) or is your pain constant? Explain

_____.

Painful Body Part #4: _____.

What makes your pain increase? _____.

What makes your pain decrease? _____.

Describe your pain (i.e. achy, dull, sharp, etc) _____.

Does your pain stay local or does it radiate to another area? _____.

Rate your current pain on a scale from 0 to 10, where 0 is no pain at all and 10 is the worst pain imaginable (circle a number): **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain ever.**

Is your pain getting: circle one (getting better, worse, or staying the same) with time? _____.

What percentage of your waking hours do you feel your pain? (0 – 100%) _____.

Does your pain vary throughout the day? (i.e. worse in the a.m./p.m.) or is your pain constant? Explain

_____.

Associated Symptoms: Since your accident have you noticed any of the following symptoms? Explain.

Numbness, tingling, or weakness of your arms or legs? (yes no) explain: _____.

_____.

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Pain with swallowing foods/liquids? (yes no)_____.

Changes in your vision/sight? (yes no)_____.

Changes in your hearing? (yes no)_____.

Any vomiting since the accident? (yes no)_____.

Any changes in bowel/bladder habits since the accident? (yes no)_____.

Any other changes to your body as a result from the accident?_____.

Past Health History (please explain if answer is yes):

Do you have any serious illnesses? (yes no)_____.

Prior hospitalizations/Surgeries? (yes no)_____.

Any prior auto accidents or physical trauma? (yes no)_____.

Are you currently taking any medications? (yes no)_____.

Do you have allergies? (yes no)_____.

Have you ever had any Xrays before? (yes no)_____.

Have you ever seen a chiropractor before? (yes no)_____.

When was your last physical exam?_____.

Do you have any prior history of your current complaints/pain from the accident? (yes no)_____.

Review of Bodily Systems: Please circle and explain any of the symptoms that you currently have.

Fever fatigue night sweats chest pain shortness of breath

Abdominal pain chronic cough rashes unexplained weight loss nausea

Vomiting diabetes musculoskeletal disorders heart disease lung disease

Family Health History: please circle and explain if your grandparents, parents, or siblings have had any of the following conditions: anemia cancer diabetes heart disease

High blood pressure epilepsy asthma kidney disease glaucoma tuberculosis

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Personal/Social History

What is your occupation?_____.

Are you married?_____. Do you have children? Ages?_____.

Do you exercise regularly?_____.

Describe your diet:_____.

What are your hobbies?_____.

Have you been able to enjoy your hobbies since the accident?_____.

Do you drink alcohol? If yes, how often?_____.

Do you use tobacco products? If yes, how often and for how long?_____.

What specific daily activities have been effected by your auto accident injuries/pain (example: taking care of children, playing with your children, sleep, driving in car, playing sports, going to the gym, etc)

_____.

_____.