Okanagan Chiropractic ~ Motor Vehicle Accident Report

General Information:

Patient Name:_____
S.I.N.:_____ Today's Date:_____
Date of Injury:_____

Habits:

Smoke: ❑None ____ Pk/day _____Years
Alcohol: ❑Never ❑ Social ❑ Light ❑Mod ❑Heavy

Employment:

At time of Accident:_____
Currently:_____
If unemployed, is it due to the accident?_____
Type of work: ❑Office/Clerical
❑Light labour ❑Mod. labour ❑Heavy labour

Past Medical History:

Surgery (include dates): _____
_____
_____
_____
_____
Fractures (include dates): _____
_____
_____
_____
Serious illnesses (dates): _____
_____
_____
_____
_____
WCB injuries (dates, treatments, settlements):
_____
_____
_____
_____
Personal injuries (dates, treatments, settlements): ___
_____
_____
_____
_____
Sports or other injuries to head, neck or back:
_____
_____
_____

Any prior history of current complaints:
1._____
2._____
3_____
Prior treatment by Chiropractor for these:
1._____
2._____
3_____

Current Medical History:

Current health problems: ❑ None
_____
_____
Current medications taken: ❑ None
_____
_____

General Accident History:

Was the accident on-the-job? ❑ Yes ❑ No
You were: ❑ Driver ❑ Front seat passenger
❑ Rear seat passenger ❑ Motorbike operator
❑ Motorcycle passenger ❑ Other:_____
Vehicle driven by:_____
Your vehicle (yr., make, model): _____
Your speed at time of accident: _____
Time of day:_____
Road conditions:❑ dry ❑ damp ❑ wet ❑ snow
❑ ice ❑ other_____
Were you: ❑ stopped❑ slowing ❑ accelerating
Other vehicle (yr., make, model): _____
Other vehicles speed at accident: _____
Was it: ❑ stopped ❑ slowing ❑ accelerating
Head restraints: ❑ none ❑ non-adjustable
❑ adjustable type ❑ don't know
If adjustable, how far above or below the top of the ear was the restraint? _____
Was the seat back adjustment altered or broken by the accident?: ❑ Yes ❑ No
Wearing Shoulder belt: ❑ Yes ❑ No ❑ don't know
Did the airbag deploy?: ❑ Yes ❑ No
If yes, were you struck?:❑ Yes ❑ No
Body position: ❑ Turned ❑ Facing forward
Head position:
❑ forward ❑ left ❑ right ❑ up ❑ down
Brakes applied? ❑ Yes ❑ No
Were you aware of impending crash? ❑ Yes ❑ No

Accident description:_____

_____

_____

_____

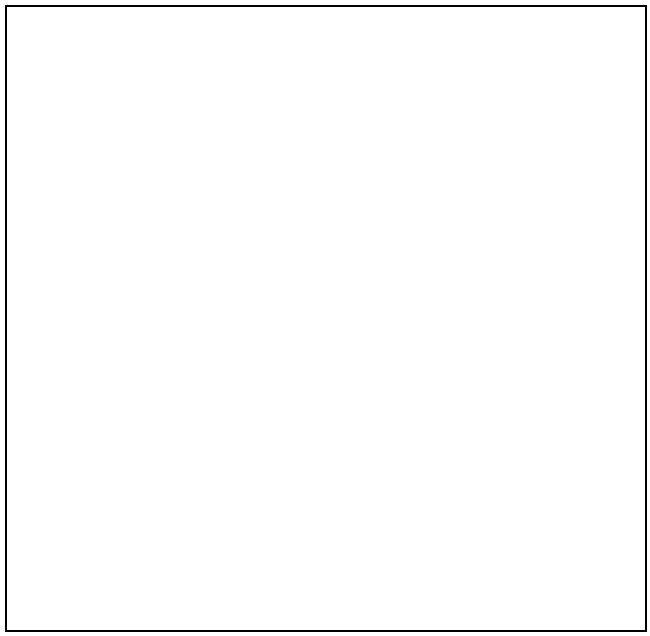
_____

_____

_____

_____

Accident diagram:



During the Crash:

Did you strike any parts of the vehicle? ❑ Y ❑ N
If yes, describe:_____

_____

_____

Did your vehicle strike any objects after the crash?
❑ Y ❑ N If yes, describe:_____

_____

Were you wearing a hat or glasses? ❑ Y ❑ N
If yes, were they still on after crash? ❑ Y ❑ N
Did you lose consciousness? ❑ Y ❑ N
If yes, for how long?_____
Estimated damage to your vehicle: _____
Estimated damage to other vehicle: _____
Did the police attend the scene? ❑ Y ❑ N
If yes, was a report made? ❑ Y ❑ N

After the Crash:

Symptoms: ❑ head aches ❑ dizziness ❑ nausea
❑ confusion ❑ neck/back pain ❑ tingling
If yes, where?_____
Where did you go after the accident?
❑ hospital ❑ home ❑ work ❑ other _____
Mode of transportation:_____

Emergency Department:

X-Rays Taken: ❑ Yes ❑ No
Body parts x-rayed:_____
❑ Cervical collar ❑ Ice ❑ Other:_____
Medications: _____
Follow up instructions: ❑ None ❑ Other _____

Treatment History:

1. Dr. _____
Type: _____
Date 1st seen: _____
Treatment type: _____
Treatment frequency: _____
Currently treating? ❑ Yes ❑ No
Any disability? ❑ Yes ___% ❑ No
Did treatment help? ❑ Yes ❑ No
If yes, describe: _____
Special tests: _____

2. Dr. _____
Type: _____
Date 1st seen: _____
Treatment type: _____
Treatment frequency: _____
Currently treating? ❑ Yes ❑ No
Any disability? ❑ Yes ___% ❑ No
Did treatment help? ❑ Yes ❑ No
If yes, describe: _____
Special tests: _____

3. Dr. _____
Type: _____
Date 1st seen: _____
Treatment type: _____
Treatment frequency: _____
Currently treating? ❑ Yes ❑ No
Any disability? ❑ Yes ___% ❑ No
Did treatment help? ❑ Yes ❑ No
If yes, describe: _____
Special tests: _____

Original Main Complaints (if accident not recent):

Severity:

- ⇨**1** = Minimal (a nuisance only)
- ⇨**2** = Slight (causes slight handicap)
- ⇨**3** = Moderate (causes significant handicap)
- ⇨**4** = Severe (intolerable)

Amount of time:

- ⇨**10%** = rare
- ⇨**25%** = occasional
- ⇨**50%** = sporadic
- ⇨**75%** = frequent
- ⇨**100%** = constant

1. Body part: _____
   Worsens when: _____
   Relieved when: _____
   Describe pain: _____
   Radiates (travels to): _____
   Severity (1-4): _____
   Amount of time in average day (as %): _____

2. Body part: _____
   Worsens when: _____
   Relieved when: _____
   Describe pain: _____
   Radiates (travels to): _____
   Severity (1-4): _____
   Amount of time in average day (as %): _____

3. Body part: _____
   Worsens when: _____
   Relieved when: _____
   Describe pain: _____
   Radiates (travels to): _____
   Severity (1-4): _____
   Amount of time in average day (as %): _____

Current Main Complaints

1. Body part: _____
   Worsens when: _____
   Pain began: _____
   Relieved when: _____
   Describe pain: _____
   Radiates (travels to): _____
   Severity (1-4): _____
   Amount of time in average day (as %): _____

Current Main Complaints

2. Body part: _____
   When pain began: _____
   Worsens when: _____
   Relieved when: _____
   Describe pain: _____
   Radiates (travels to): _____
   Severity (1-4): _____
   Amount of time in average day (as %): _____

3. Body part: _____
   Pain began: _____
   Worsens when: _____
   Relieved when: _____
   Describe pain: _____
   Radiates (travels to): _____
   Severity (1-4): _____
   Amount of time in average day (as %): _____

4. Body part: _____
   Pain began: _____
   Worsens when: _____
   Relieved when: _____
   Describe pain: _____
   Radiates (travels to): _____
   Severity (1-4): _____
   Amount of time in average day (as %): _____

5. Body part: _____
   Pain began: _____
   Worsens when: _____
   Relieved when: _____
   Describe pain: _____
   Radiates (travels to): _____
   Severity (1-4): _____
   Amount of time in average day (as %): _____

Self Assessment as of Today:

% change positive or negative (list for separate areas)

1. _____
2. _____
3. _____
4. _____
5. _____