

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:

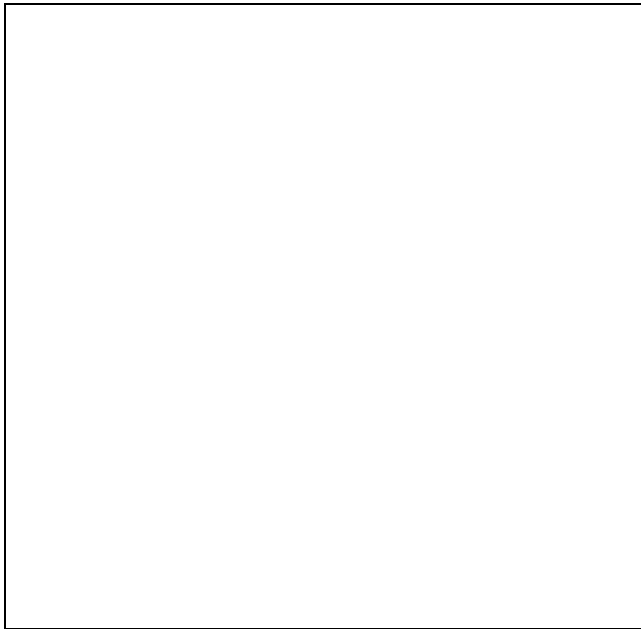
forward left right up down

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. _____