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Centro Chiropractic Clinic

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Location of Accident \_\_\_\_\_

Brief Description of Accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Accident Details**

Your Vehicle information (year, make model): \_\_\_\_\_

Were you the: Driver, front passenger, rear passenger? \_\_\_\_\_

If you were the passenger, were you sitting on the: driver's 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-ended, side-impact, front collision, other? \_\_\_\_\_

The Other Vehicle(s) information: (year, make, model): \_\_\_\_\_

The Road Conditions at the time of the accident were: (dry, wet, rain, snow, other)? \_\_\_\_\_

What was the Estimated speed of the other vehicle: \_\_\_\_\_

What type of Headrest does your vehicle have: fixed, adjustable? \_\_\_\_\_

What position was the headrest in: lowest position, middle position, top position? \_\_\_\_\_



Was your Seatback broken? **Yes** **No**

Did you use a: Shoulder/lap belt, lap belt only, car seat, no seatbelt used, other? \_\_\_\_\_

Did your Airbag deploy as a result of the accident? **Yes** **No**

If yes, were you struck by the airbag? **Yes** **No**

At the time of impact, what was your head position: facing forward, looking up, looking down, turned to the left, turned to the right, other. Explain:

\_\_\_\_\_

At the time of impact, what was the Position of your torso (upper body): facing forward, leaning back, leaning forward, turned to the left, turned to the right, other. Explain:

\_\_\_\_\_

Were you aware of the impending collision with the other vehicle? **Yes** **No**

Did you Brace for the impact? **Yes** **No**

Were your Hands on the steering wheel at the time of impact? **Yes** **No**  
If yes, which hand(s): **both** **left only** **right only**

Was your Foot on the brake pedal at the time of impact? **Yes** **No**  
If yes, was it knocked off the brake pedal due to the impact? **Yes** **No**

Did the collision move your vehicle? **Yes** **No**  
If yes (how far)? \_\_\_\_\_ feet

Were you wearing hat, glasses, etc at the time of the collision? **Yes** **No**  
If yes, were they knocked off? **Yes** **No**

Did any part of your body strike any object inside the car?

**Yes** **No**  
If yes, explain: \_\_\_\_\_

Did you lose consciousness after the accident? **Yes** **No**  
If yes, for how long? \_\_\_\_\_



Describe the Damage to your vehicle: \_\_\_\_\_

What dollar amount did the body shop estimate the damage to be? \_\_\_\_\_

Describe the Damage to other vehicle(s) involved: \_\_\_\_\_

Did the Police respond to the accident?      **Yes**                      **No**

Did they file a Report?                      **Yes**                      **No**

Did you file a DMV accident report?      **Yes**                      **No**

Where did you go immediately after the accident? \_\_\_\_\_

How did you get there? \_\_\_\_\_

Did you go to the Hospital?      **Yes**                      **No**

What hospital did you go to? \_\_\_\_\_

What was their diagnosis? \_\_\_\_\_

What body part(s) did they x-ray? \_\_\_\_\_

What other tests, exams did they do on you? \_\_\_\_\_

What medications did they give you? \_\_\_\_\_

**Immediately after the accident symptoms:**

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 or bruises from the accident?      **Yes**                      **No**

If yes, explain: \_\_\_\_\_

**Your Present Symptoms:**

**In this section, you will describe your current pain. You will list, separately, each part of your body that is in pain and you will answer some questions regarding the pain of that part of your body.**

**Example of body parts are: headaches, neck pain, upper back pain, mid back pain, low back pain, hip pain, knee pain, ankle pain, foot pain, shoulder pain, elbow pain, wrist pain, hand pain, chest pain, etc.**

**Body Part 1:** \_\_\_\_\_

What makes the pain increase?: \_\_\_\_\_

What makes the pain decrease?: \_\_\_\_\_

Describe the type of pain you feel: \_\_\_\_\_

Does the pain stay in this body part, or does it radiate/move to another part of the body?  
\_\_\_\_\_

On a scale of 0-10 with 0 representing absolutely no pain, and 10 representing the worst pain imaginable, what is your pain level **currently**? (circle your choice)

**1      2      3      4      5      6      7      8      9      10**

What is your pain level **usually**?: **1   2   3   4   5   6   7   8   9   10**

Is the pain: getting better with time, staying the same, getting worse with time? \_\_\_\_\_

What percentage of your waking hours do you feel the pain (0-100%): \_\_\_\_\_

Does your pain vary throughout the day? (for example, worse at the end of the day) or is it constant?

**Yes                      No**

If your pain varies, explain: \_\_\_\_\_



**Body Part 2:** \_\_\_\_\_

What makes the pain increase?: \_\_\_\_\_

What makes the pain decrease?: \_\_\_\_\_

Describe the type of pain you feel: \_\_\_\_\_

Does the pain stay in this body part, or does it radiate/move to another part of the body?: \_\_\_\_\_

On a scale of 0-10 with 0 representing absolutely no pain, and 10 representing the worst pain imaginable, what is your pain level currently? (circle your choice)

**1      2      3      4      5      6      7      8      9      10**

What is your pain level usually?: **1   2   3   4   5   6   7   8   9   10**

Is the pain: getting better with time, staying the same, getting worse with time?    **Yes                  No**

What percentage of your waking hours do you feel the pain (0-100%): \_\_\_\_\_

Does your pain vary throughout the day? (for example, worse at the end of the day) or is it constant?

    If your pain varies, explain: \_\_\_\_\_

**Body Part 3:** \_\_\_\_\_

What makes the pain increase?: \_\_\_\_\_

What makes the pain decrease?: \_\_\_\_\_

Describe the type of pain you feel: \_\_\_\_\_

Does the pain stay in this body part, or does it radiate/move to another part of the body?: \_\_\_\_\_

On a scale of 0-10 with 0 representing absolutely no pain, and 10 representing the worst pain imaginable, what is your pain level currently? (circle your choice)

**1      2      3      4      5      6      7      8      9      10**

What is your pain level usually?: **1   2   3   4   5   6   7   8   9   10**



Is the pain: getting better with time, staying the same, getting worse with time?

If yes, explain: \_\_\_\_\_

What percentage of your waking hours do you feel the pain (0-100%): \_\_\_\_\_

Does your pain vary throughout the day? (for example, worse at the end of the day) or is it constant?

**Yes**

**No**

If your pain varies, explain: \_\_\_\_\_

**Body Part 4:** \_\_\_\_\_

What makes the pain increase?: \_\_\_\_\_

What makes the pain decrease?: \_\_\_\_\_

Describe the type of pain you feel: \_\_\_\_\_

Does the pain stay in this body part, or does it radiate/move to another part of the body?:

On a scale of 0-10 with 0 representing absolutely no pain, and 10 representing the worst pain imaginable, what is your pain level currently? (circle your choice)

**1      2      3      4      5      6      7      8      9      10**

What is your pain level usually?: **1   2   3   4   5   6   7   8   9   10**

Is the pain: getting better with time, staying the same, getting worse with time?    **Yes**                      **No**

What percentage of your waking hours do you feel the pain (0-100%): \_\_\_\_\_

Does your pain vary throughout the day? (for example, worse at the end of the day) or is it constant?

If your pain varies, explain: \_\_\_\_\_



If, after the accident, you began to have any of the symptoms in this section, please explain in detail:

**Weakness of your arm(s) or leg(s)**      **Yes**      **No**

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**Numbness of your arm(s) or leg(s)**      **Yes**      **No**

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**Tingling of your arm(s) or leg(s)**      **Yes**      **No**

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**Pain with swallowing food or liquids:**      **Yes**      **No**

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**Changes with your vision:**      **Yes**      **No**

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**Changes with your hearing:**      **Yes**      **No**

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**Vomiting:**      **Yes**      **No**

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**Bowel changes:**      **Yes**      **No**

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**Bladder changes:**      **Yes**      **No**

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**Is there any other change to your body that you feel may be a result of the accident?**

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**Your Past Health History (please explain fully):**

Do you have any Serious illnesses? \_\_\_\_\_

Have you been Hospitalized before? \_\_\_\_\_

Have you had any surgeries? \_\_\_\_\_

Have you experienced any previous physical Trauma?      **Yes**                  **No**

Have you had any other accidents?    **Yes**                  **No**

How many Pregnancies have you had? \_\_\_\_\_

Are you currently taking any Medications?    **Yes**                  **No**

Do you have Allergies?                  **Yes**                  **No**

Have you ever had any X-rays before?      **Yes**                  **No**

Have you seen a chiropractor before (if yes, name and city)? \_\_\_\_\_

When was your Last physical exam? \_\_\_\_\_

Do you have Any prior history of your current complaints/pains? \_\_\_\_\_

**Review of Symptoms: please circle and explain any of the symptoms 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 (of only your grandparents, parents, or siblings): (please circle and explain who had/has the condition, and how old they were when they first were diagnosed)**

- Anemia                  cancer                  diabetes                  heart disease                  high blood pressure
- Epilepsy                  psychological disorders                  asthma                  kidney disease                  glaucoma                  tuberculosis





**Your Personal/Social History**

What is your occupation? \_\_\_\_\_

Are you Married?     **Yes**                      **No**

What are the ages of your Children? \_\_\_\_\_

Describe your Diet:  
\_\_\_\_\_

Do you Exercise regularly?   **Yes**                      **No**

Do you have Hobbies?                      **Yes**                      **No**

    If yes, are you able to do your hobby since the accident?   **Yes**                      **No**

Do you drink Alcohol?                      **Yes**                      **No**

    If yes, how much, how often? \_\_\_\_\_

Do you use Tobacco?                      **Yes**                      **No**

    If yes, how much, and for how long? \_\_\_\_\_