CAD INJURY HISTORY FORM

GENERAL INFORMATION

Patient' Name___________________________
Today's Date___________________________
Date of Injury___________________________
Marital Status ❒M ❒S ❒W ❒D
Habits:
Smoke: ❒None Pk/day___Yrs____
Alcohol: ❒Never ❒Light ❒Mod ❒Heavy

Employment:
At time of accident:___________________________
❒Unemployed
Currently:___________________________
❒Unemployed
Due to accident? ❒Yes ❒No
Type of work: ❒Office/clerical ❒Light labor ❒Mod labor ❒Heavy labor

PAST MEDICAL HISTORY

Surgeries (dates and residuals):_______________

Fractures (dates and residuals) _______________

Serious illness (dates and residuals) __________

Worker's comp. injuries (date, TX, awards, residuals)

Personal Injuries (date, TX, awards, residuals)

Sports or other injuries to head, neck, or back:

Any prior HX of current complaints:
1. ___________________________
2. ___________________________
3. ___________________________

Prior TX by DC for these:
1. ___________________________
2. ___________________________
3. ___________________________

Current Medical History:
Current health problems: ❒None

Current medications taken: ❒None

Accident History. General:
Was the accident on the job? ❒Yes ❒No
You were: ❒Driver ❒Front Passenger ❒Rear passenger ❒Motorcycle operator ❒Motorcycle Passenger ❒Other___________________
Vechicle driven by: ___________________
Your vehicle (year-make-model):___________
Your estimated speed at moment of accident:___
❒Stopped ❒Slowing ❒Accelerating
Other vehicle (year-make-model):___________
Time of day: ❒Daylight ❒Dawn ❒Dusk ❒Dark
Road conditions: ❒Dry ❒Damp ❒Wet ❒Snow ❒Ice ❒Other_______________
Head restraints: ❒None ❒Integral type
❒Adjustable type: ❒Up ❒Down
❒Don't Know
If adjustable was the position altered by the accident? ❒Yes ❒No
Was the seat back adjustment altered by the accident? ❒Yes ❒No
Was the seat broken? ❒Yes ❒No
Lap Belt: ❒Wearing ❒Not wearing ❒Don't Know
Shoulder belt: ❒None ❒Wearing ❒Not wearing ❒Don't know
Did airbag deploy? ❒Yes ❒No
If yes, were you struck?` ❒Yes ❒No
Body position: ❒Good ❒Forward
Other:___________________
Head position: ❒Forward ❒Left ❒Right ❒Up ❒Down

Accident History General (cont'd)

Hands ☐One on wheel ☐Two on wheel
☐N/A
Brakes applied? ☐Yes ☐
Accident Description:

____
____
____
____
____
____

Accident Diagram:

Aware of impending crsh? ☐Yes ☐No

During the Crash:

Did you strike any parts of the vehicle? ☐Yes ☐No
If yes, describe ______________
Did vehicle strike any objects after the crash?
If yes, describe ______________
Wearing hat or glasses? ☐Yes ☐No
If yes, still on after the crash? ☐yes ☐No
Did you lose consciousness? ☐Yes ☐No
If yes, for how long?______________
Estimated property damage to your vehicle:
$______________
Estimated property damage to other vehicle(s):
☐None ☐Minimal ☐Moderate ☐Major
Were the police on scene? ☐Yes ☐No
If yes, was a report made? ☐Yes ☐No

After the Crash

Symptoms: ☐Headache ☐Dizziness
☐Nausea ☐Confusion/disorientation
☐Neck pain ☐Paresthesia
☐Extremity pain where?______________
Back pain
When did symptoms first appear? ☐Immediately
__________hrs afterward
Where did you go after accident? ☐Home
☐Work ☐Hospital
Mode of transportation?______________
Pvt. Doctor______________

Emergency department

Hospital______________
X-Rays ☐Yes ☐No
Body parts imaged______________
Results______________
Lab work ☐Yes ☐No
☐Cervical collar ☐Ice
Medications:______________
Other:______________
Follow Up instructions______________

Treatment History:

1. Dr. ______________
Specialty:__________Date first seen__________
Referred by:__________TX type__________
TX frequency:__________TX duration:__________
Currently treating? ☐Yes ☐No
Any disability? Yes ☐No
If Yes, describe______________
Special tests:______________
Referred to:______________
Did TX help? ☐Yes ☐No
Notes:______________

2. Dr. ______________
Specialty:__________Date first seen__________
Referred by:__________TX type__________
TX frequency:__________TX duration:__________
Currently treating? ☐Yes ☐No
Any disability? Yes ☐No
If Yes, describe______________
Special tests:______________
Referred to:______________
Did TX help? ☐Yes ☐No
Notes:______________