DRAEGER
Chiropractic & Laser Center
2114 Schofield Ave. Weston, WI 54476

Patient Automobile Accident History

Today's Date:_____

Personal Information

Name:	Home Phone:
Street Address:	Work Phone:
City/State/Zip:	Cell Phone:
Date of Birth:	Email:
Social Security #:	
Driver's License#:	
Spouse's Name:	Spouse's Employer:
Emergency Contact:	Emergency Contact's Phone:

❑ Yes ❑ No Do you commute to work? If so, how far?

Occupation:	Employer:

❑ Yes ❑ No Have you missed time from work? If no, who told you to return to work?

If yes, were you off work full-time? ❑ Yes ❑ No Dates:

Were you off work part-time? ❑ Yes ❑ No Dates:

Completely off work? ❑ Yes ❑ No Dates:

What type of physical activity is required of you at work?

Is there alternative work available for you? ❑ Yes ❑ No

❑ Yes ❑ No Are you a smoker? If so, how much?

❑ Yes ❑ No Do you consume caffeine? If so, how much?

❑ Yes ❑ No Are you a female"? If so, are you pregnant? ❑ Yes ❑ No

Auto Information

Your Car Insurance Company:

Agent's Name: Agent's Phone #:

Past Medical History

❑ Yes ❑ No Do you suffer from any condition other than that for which you are now consulting us? If yes, what?

❑ Yes ❑ No Have you ever seen a chiropractor before?

Date: Doctor: Condition:

❑ Yes ❑ No Are you allergic to anything? If so, what?

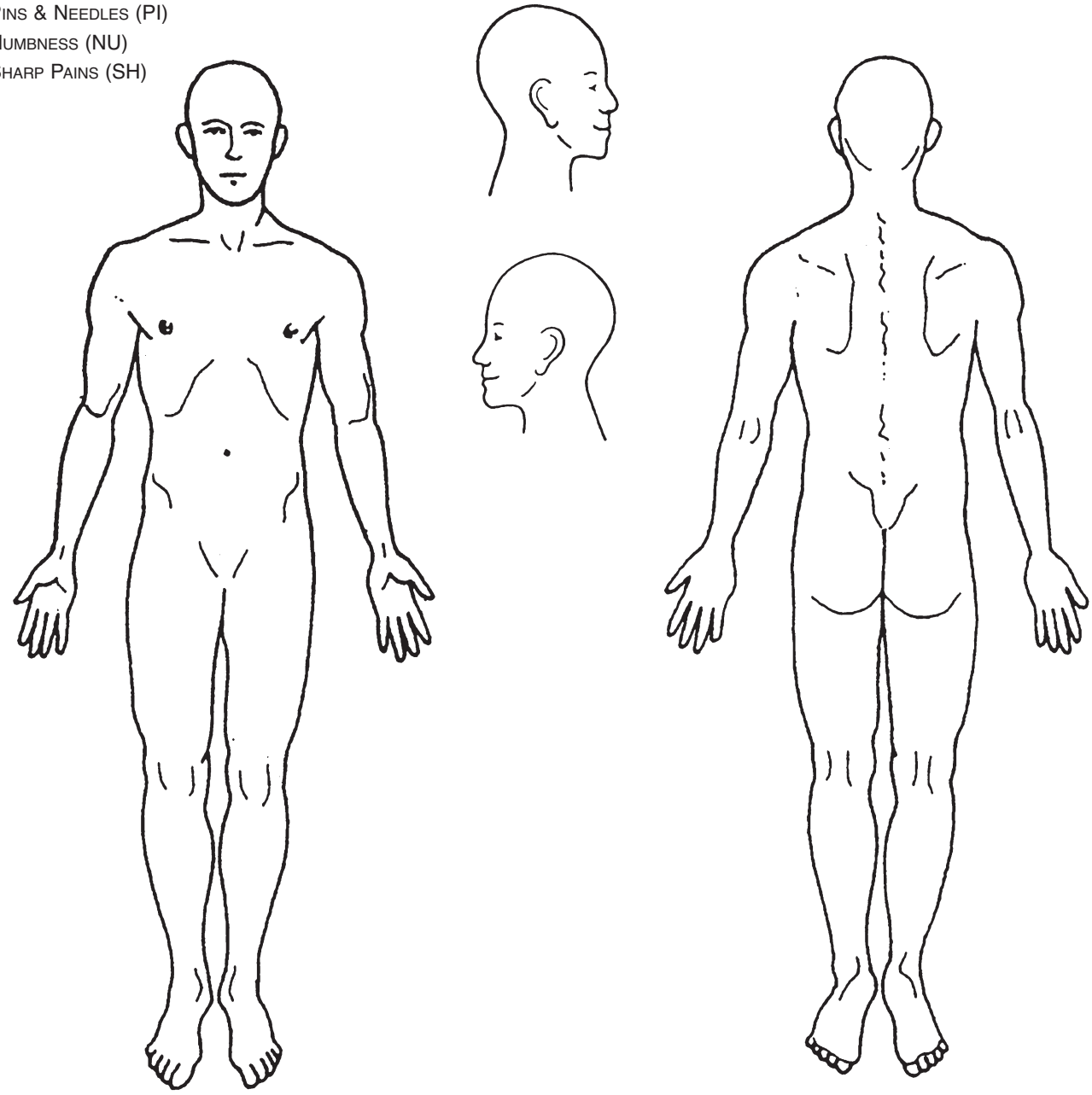
❑ Yes ❑ No Do you take prescription drugs, over-the-counter drugs, vitamins or supplements? If yes, please list drug, reason, frequency and dosage.

❑ Yes ❑ No Have you ever had major illnesses, injuries, falls, hospitalizations, auto accidents or surgeries? If yes, please list dates and conditions.

Chief Complaint

Be sure to fill out this section as accurately as possible. Mark the area with the described sensation. Use the appropriate symbols. If there is more than one area of discomfort, please rate the pain on a scale of 0 to 100 next to each are, with 0 being no pain and 100 being intolerable pain.

XXX Burning (BU)
(((Aching Pain (AC)
000 Pins & Needles (PI)
- - - Numbness (NU)
: : : Sharp Pains (SH)



0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

NO PAIN PAIN SCALE: INTOLERABLE

What Makes the Condition Better?

Head Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

What Makes the Condition Worse?

Head Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

Accident Information

Date of Accident:	Time of Accident: ❑ AM ❑ PM
Driver of Vehicle:	Where were you seated:
Vehicle's Owner:	Year/Model of vehicle you were in:
Approximate damage of the vehicle you were in:	Where did the accident occur:

Your vehicle: ❑ Hit another vehicle ❑ Was hit in the: ❑ Right Side ❑ Left Side ❑ Rear ❑ Front

Type of Accident: ❑ Head-on collision ❑ Broad-side collision ❑ Rear-end collision
❑ Front-impact (rear-ended vehicle in front) ❑ Single vehicle collision ❑ Other

Were the internal parts of the vehicle broken? ❑ Yes ❑ No If so, which ones?

What were the road conditions at the time: ❑ Icy ❑ Rainy ❑ Wet ❑ Clear ❑ Dark

What was the visibility at the time: ❑ Poor ❑ Fair ❑ Good

Number of vehicles involved: 1 2 3 4 5 +	Year/Model of other vehicle(s):

Impact/Seatbelt/Headrest/Speed/Head/Body Position

Describe in your own words what happened to you upon impact:

❑ Yes ❑ No Did you see the accident coming?

❑ Yes ❑ No Did you brace for impact?

❑ Yes ❑ No Did you have your hands on the steering wheel at impact?

❑ Yes ❑ No Where you wearing glasses, a hat or dentures? Where were they after the impact?

❑ Yes ❑ No Were seatbelts worn? ❑ Yes ❑ No Were shoulder harnesses worn?

❑ Yes ❑ No Does your vehicle have airbags? ❑ Yes ❑ No Did they release?

❑ Yes ❑ No Does your vehicle have headrests? If so, what was its position compared to your head after the accident?

❑ Yes ❑ No Was your vehicle braking?

❑ Yes ❑ No Was your vehicle moving at the time of the accident? ❑ slowing down ❑ speeding up ❑ constant speed

What was the speed limit on the road you were traveling?

How many people were in your vehicle?

Head/Body position at the time of impact:

Head: ❑ Straight ❑ Turned Right ❑ Turned Left

Body: ❑ Straight ❑ Turned Right ❑ Turned Left

❑ Yes ❑ No Did your head/body hit any parts of the interior of the vehicle? If yes, which parts?

Ability to Move Body

❑ Yes ❑ No Could you move all parts of your body? If no, what parts and why not?

❑ Yes ❑ No Were you able to get out of the vehicle unaided? If no, why not?

As a result of the accident were you: ❑ Rendered unconscious ❑ Dazed, situation vague ❑ Shaken up but could function

Where were you in the vehicle prior to the accident?

Where were you in the vehicle after the accident?

Indicate your ability to perform the following activities. Please use these codes:

U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't tried

	Lying on back		Gripping		Pushing		Turning over in bed
	Lying on side		Climbing		Kneeling		Standing 1 hr+
	Bending forward		Pulling		Stooping		Walking short distances
	Getting in/out car		Dressing self		Sitting at table		Cough/Sneeze
	Sleeping		Sexual Activity		Reaching		Lying flat on stomach
	Balancing	Other activities:					

First Doctor/Hospital/Clinic

❑ Yes ❑ No Did you seek medical help immediately after the accident? If yes, how did you get there?

❑ Someone drove you ❑ You drove ❑ Police ❑ Ambulance

Where did you go?

❑ Yes ❑ No Were you examined?

❑ Yes ❑ No Were x-rays taken?

❑ Yes ❑ No Were you given treatment? If so, what type?

Did you receive any benefit from this treatment?

Date of your last treatment?

❑ Yes ❑ No Did the doctor refer you to another health professional? If so, to who and for what?

❑ Yes ❑ No Did you follow the doctor's recommendations? If no, why not?

Second Doctor/Clinic

Doctor/Clinic: Date of first visit:

❑ Yes ❑ No Were you examined?

❑ Yes ❑ No Were x-rays taken?

❑ Yes ❑ No Were you given treatment? If yes, what type?

What benefits did you receive from this treatment?

Date of last treatment?

Symptoms from Accident

❑ Yes ❑ No Did you receive any bruises from the seatbelts? If so, where?

❑ Yes ❑ No Did you receive any other bleeding cuts or bruises? If cut, where?

If bruises, where?

Please describe how you felt. Please be specific.

Immediately after the accident:

Later that date:

The next day(s):

Check symptoms that have become apparent since the accident/injury:

	Nervousness		Loss of balance		Sleeping trouble		Headache
	Neck pain/stiffness		Loss of smell		Toe numbness		Fainting
	Mid back pain		Loss of taste		Finger numbness		Anxiety
	Low back pain		Loss of memory		Cold hands		Seizures
	Eye sensitivity		Pins/needles arms		Cold feet		Visual changes
	Pain behind eyes		Pins/needles legs		Chest pain		Forgetfulness
	Dizziness		Short of breath		Constipation		Blurred vision
	Cold sweats		Head being heavy		Diarrhea		Double vision
	Face flushed		Irritability		Fatigue		Confused
	Ringing in ears		Depression		Tension		Disoriented

❑ Yes ❑ No Does the pain interfere with your sleep? If so, how many times per night?

❑ Yes ❑ No Does heat affect the pain? If so, how?

❑ Yes ❑ No Does cold affect the pain? If so, how?

❑ Yes ❑ No Do you wear a heel lift? If so, which side?

❑ Yes ❑ No Did you have any physical complications just before the accident? If yes, please describe in detail:

❑ Yes ❑ No Prior to this accident, have you ever had similar symptoms? If yes, please explain.

❑ Yes ❑ No Have you been in accidents prior to this one? If yes, when? Where?

How were you treated?

Results of treatment.

❑ Yes ❑ No Do you have any congenital (birth) factors which relate to this problem? If yes, please describe:

Have you had any problems with the following areas? Mark Y if yes – Mark N if no

	Eyes		Urinary		Internal Organs		Ears, nose, mouth
	Muscles		Blood		Heart		Nerves
	Allergies		Lungs/breathing		Skin		Other
	Intestines		Psychological				

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. I also give permission for my case to be used for research purposes if it is so approved.

patient signature: _____ Date: _____

guardian/legal representative signature: _____ Date: _____

d.c./c.a. signature: _____ Date: _____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefor it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be full informed in consenting to treatment.

Chiropractic offices use trained staff personnel to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, etc. Occasionally, when your Chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

Specific risk possibilities associated with Chiropractic care:

Stroke– Stroke is the most serious complication of Chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located withing the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 to 5.85 million treatments. (CMAJ 2001 Oct. 2; 165 (7):905-6). The annual incidence of a spontaneous stroke is estimated at 1 to 1.5 per 100,000 (NEJM, 1994; 330:339-397). The results of a retrospective study conducted by Haldeman S, Et. Al, suggested that stroke should be considered a random and unpredictable complication of any neck movement including cervical manipulation (J Neurol 2002 Aug: 249(8): 1098-104).

Soreness– Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While is is not general dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.

Soft Tissue Injury– Occasionally Chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury– Manual adjustments to the thoracic spine, in rare cases, May cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns– Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic or staff if they occur.

Other Problems– There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is your goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient's Name Printed

Today's Date

Patient's Signature

Parent of Guardian Signature for Minor