ALIGN Chiropractic
SPINE & SPORTS REHAB

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Carlisle, PA 17015
P: (717) 241-9355 F: (717) 241-9356

Date: _____

Name: _____ Date of Birth: _____

Auto Insurance Co.: _____ Claim#: _____

Have you retained an attorney? ☐ Yes ☐ No Name: _____ Address: _____

- Date of Accident: _____ Time of Day: _____
- Location of Accident: _____
- In your own words, please describe the accident: _____

  _____
- Were you: ☐ Driver ☐ Passenger If passenger, were you in the: ☐ Front seat ☐ Back seat
- Number of people in your vehicle? _____ Other vehicle(s)? _____
- What size vehicle were you driving? ☐ Compact ☐ Mid-size ☐ Full-size ☐ Truck ☐ SUV
- What size vehicle was the other vehicle(s) involved in the accident?: ☐ Compact ☐ Mid-size ☐ Full-size ☐ Truck ☐ SUV
- What were the road surface conditions?: ☐ Dry ☐ Wet ☐ Snow ☐ Ice ☐ Other: _____
- How fast were you traveling just before the accident?: ☐ Stopped ☐ Less than 5 mph ☐ 5-15 mph ☐ 16-30 mph ☐ 31-45 mph ☐ 46+ mph
- If the accident involved another vehicle, how fast would you approximate the other vehicle was traveling just before the accident: ☐ Stopped ☐ Less than 5 mph ☐ 5-15 mph ☐ 16-30 mph ☐ 31-45 mph ☐ 46+ mph
- By your estimation, how much damage occurred to your vehicle: ☐ Minor/Minimal ☐ Moderate ☐ Significant ☐ Vehicle Totaled
- If another car was involved, how much damaged occurred to it: ☐ Minor/Minimal ☐ Moderate ☐ Significant ☐ Vehicle Totaled
- If you struck the vehicle in front of you, did you hit it: ☐ Straight on ☐ Off to the left ☐ Off to the right
- If you were hit from behind, was the impact from: ☐ the center ☐ more to the left ☐ more to the right
- Were you aware that you were going to be involved in an accident prior to the injury: ☐ Yes ☐ No
- Was your foot on the brake at the time of impact? ☐ Yes ☐ No If yes, did your car move forward after impact? ☐ Yes ☐ No
- Were you wearing a seat belt? ☐ Yes ☐ No
- Did an airbag deploy during the accident? ☐ Yes ☐ No

- What was the position of your head at the time of impact? ☐ turned to right ☐ turned to left ☐ looking straight ahead ☐ looking in the rearview mirror ☐ Other:_____
- Were you sitting straight up at time of impact? ☐ Yes ☐ No
- What was the distance from the back of your head to the headrest? _____ inches What was the height of your headrest?:____ in.
- Did anything in the vehicle strike you? ☐ Yes ☐ No If yes, what and where?_____
- Did your head strike anything in the vehicle? ☐ Yes ☐ No If yes, what?_____
- Were you able to remove yourself from the vehicle? ☐ Yes ☐ No
- Were you taken from the accident via ambulance? ☐ Yes ☐ No Were you examined and/or treated by an emergency medical crew at the site of the accident? ☐ Yes ☐ No If you went to the hospital, which hospital did you go to:_____
- Were police notified? ☐ Yes ☐ No If yes, was an accident report taken?: ☐ Yes ☐ No
- Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes, please describe:_____
- Have you ever been involved in a motor vehicle accident in the past? ☐ Yes ☐ No If yes, please describe, including date(s) and type(s) of accidents, as well as any injuries received.:_____
- Please describe how you felt:
  1. IMMEDIATELY AFTER the accident:_____
  2. LATER THAT DAY:_____
  3. THE NEXT DAY:_____
- Did you have any visible injuries following the accident (swelling, bruising, etc.)? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you seen any other health care providers since the accident? ☐ Yes ☐ No
  If yes, please list the doctor's name/address:_____
  What type of treatment did you receive:_____
- Have you had any special studies performed for injuries sustained as a result of the accident?: ☐ Yes ☐ No
  If yes, what studies were performed: ☐ X-rays ☐ MRI ☐ CT scan ☐ Other:_____
- What are your PRESENT complaints and symptoms?:_____

- If you are experiencing pain, how would you describe your pain:

  ☐ Dull ☐ Ache ☐ Sharp ☐ Stiffness ☐ Spasm ☐ Soreness ☐ Boring ☐ Shooting ☐ Burning

  ☐ Throbbing ☐ Stabbing Other Associated Symptoms: ☐ Weakness ☐ Numbness ☐ Tingling

- Since the time of the accident, are your symptoms: ☐ Getting worse ☐ Staying the same ☐ Getting better
- What makes your pain better?:_____
- What makes your pain worse?:_____
- Is your pain worse with coughing, sneezing, deep breathing, or when going to the bathroom?: ☐ Yes ☐ No
- Are you having any problems with memory or concentration as a result of your motor vehicle accident? ☐ Yes ☐ No
- Do you remember everything from the time of impact until after the impact?: ☐ Yes ☐ No
- Did you lose consciousness as a result of the accident?: ☐ Yes ☐ No
- Have you noticed any visual disturbances as a result of the accident?: ☐ Yes ☐ No
- Have you had any ringing of the ears as a result of the accident?: ☐ Yes ☐ No
- Were you nauseated / dizzy as a result of the accident?: ☐ Yes ☐ No
- Rate your current pain on a scale of 0(least pain) - 10 (most pain): ___ Average ___Best ___Worse
- How often are your symptoms present?:

  ☐ Constant (81-100%) ☐ Frequent (51-80%) ☐ Occassional (26-50%) ☐ Intermittent (25% or less)

- Have you lost time from work as a result of this accident?: ☐ Yes ☐ No

  If yes, please complete the following questions:

  1. Last day worked:_____
  2. Type of Employment:_____
  3. Are you being compensated for your time lost from work?: ☐ Yes ☐ No

- Do you notice any activity restrictions as a result of this injury?: ☐ Yes ☐ No

  If yes, please describe in detail:_____

  _____

- Are you having difficulty sleeping since the accident?: ☐ Yes ☐ No If yes, please describe:_____

  _____

- Other pertinent information:_____

  _____

  _____

I have answered the above truthfully and to the best of my knowledge.

Patient signature:_____ Date:_____

Provider signature:_____ Date:_____