Auto Accident Report

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Back in the Game
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PIP # (Accident claim #)

Name: Date of accident:

Please describe or sketch the accident:

Year/make/ model of your car: other car:

Total # cars involved: Est. speed of your car: Other car:

Were you hit from: ☐ Front ☐ Back ☐ Right side ☐ CLeft side

Were you: ☐ Driver ☐ Passenger Were you wearing a safety belt: ☐ Yes ☐ No

Were you aware of the impending collision? ☐ Yes ☐ No Road conditions were:

Did you hit anything on the inside of the car?

Describe you head position at the time of the impact:
(If dazed, knocked unconscious and for how long)

Have you been examined / treated since the accident (ER):

Previous accidents resulting in injury?

Your Health Insurance Co. Policy #

Phone #: Adjuster:

If being represented by attorney please give contact:

Back in the Game
SPORTS MEDICINE, LLC

Patient Health Questionnaire for new patients

Present Complaint: (Describe your symptoms)

1) How often do you experience symptoms?

☐ Constant (100-76%) ☐ Frequent (75-51%) ☐ Occasional (50-26%) ☐ Intermittent ((>26%)

2) Describe the nature of your symptoms:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

3) Since your problem began, is the pain:

◯ Getting Better ◯ Not Changing ◯ Getting Worse

4) indicate the average intensity of your symptoms:

◯ 0 (no pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (worst pain)

***Consent to treat: Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy, graston, and manual manual muscle therapy) are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare including fractures and damage to the arteries.

Other Medical History

☐ Allergies ☐ Depression ☐ Osteoporosis ☐ Prostate problems
☐ Arthritis ☐ Diabetes ☐ Skin condition ☐ Gynecology problems
☐ Asthma ☐ Hepatitis ☐ Stroke ☐ Thyroid problems
☐ Cancer ☐ Hypertension ☐ Scoliosis

In the last 30 days:

☐ Unexplained weight loss
☐ Unusual headaches
☐ Infection or Fever

Surgeries

☐ Cardiovascular ☐ Abdominal / other organ ☐ Upper / lower extremities ☐ Spine / neurological

Parent Family History

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ High blood pressure / Heart ☐ Back problems

Prescription medication

☐ Asthma / Allergy ☐ Anti-coagulant ☐ Anti-depressant ☐ Anti-inflammatory ☐ Antibiotic
☐ Cortico-steroids ☐ Thyroid ☐ Pain reliever ☐ Birth control ☐ Other

Previous fractures or serious hospitalizations:

Please give your height, weight, other significant stressors):

I have read and understand the above statements regarding financial responsiblity, privacy practices, and treatment side-effects.

Signature ____________________