



# BACKFIT CHIROPRACTIC AND REHAB.

## Personal Injury Accident Information

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

❖ Date of Accident: \_\_\_\_\_ Time of Day: \_\_\_\_\_

❖ Were you:  Driver  Passenger  Front Seat  Back Seat  
 Passenger Side  
 Driver Side

❖ Number of people in your vehicle? \_\_\_\_\_ Other vehicle? \_\_\_\_\_

❖ What direction was the car headed?  North  South  East  West  
Location of Accident: \_\_\_\_\_ Name of county: \_\_\_\_\_

❖ What direction was the other vehicle headed?  North  South  East  West

❖ Were you struck from:  Behind  Front  Left Side  Right Side

❖ Were you knocked unconscious?  No  Yes If yes, for how long? \_\_\_\_\_

❖ Were the police notified?  No  Yes

❖ In your own words, please describe the accident:

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

❖ What effects did the accident have upon you (physically & emotionally):  
during the accident: \_\_\_\_\_  
immediately after the accident: \_\_\_\_\_  
later that day: \_\_\_\_\_  
the next day: \_\_\_\_\_

❖ What are your present complaints and symptoms?

\_\_\_\_\_

❖ Where were you taken after the accident? \_\_\_\_\_

\_\_\_\_\_

❖ Have you been treated by another Doctor since the accident?  No  Yes

If yes, who? \_\_\_\_\_

What types of treatment did you receive? \_\_\_\_\_

Were you given any medications? If yes, please list \_\_\_\_\_

Have you self-treated? If yes, how? (for e.g., rest, ice, meds, other doctors) \_\_\_\_\_

\_\_\_\_\_

**WORK:**

- ❖ As a result of the accident, have you lost work time?  No  Yes

If yes, please complete the following:

Date last worked: \_\_\_\_\_

What specific duties do you perform at work (for e.g., sitting, lifting, typing.): \_\_\_\_\_

\_\_\_\_\_

Have you noticed any limitations when performing your job? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Are you concerned about the affect of this accident on your job? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Has your employer been accomodating to your needs? Please explain \_\_\_\_\_

\_\_\_\_\_

**RELATIONSHIPS:**

- ❖ Have you noticed any new or increasing stresses at home with your significant other, children, siblings, parents, co-workers? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERSONAL LIFE:**

- ❖ Have you had any difficulties performing everyday activities? (For example; grooming, bathing, child care, reading, shopping, driving...) If yes, how long and please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- ❖ Have you had any difficulty performing any duties around your home? (For example; yard work, cleaning, car care...) If yes, how long and please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- ❖ Have you had any difficulties performing any recreational activities/hobbies? (For example; working out at the gym, hiking, tennis, golf, swimming, yoga...) If yes, how long and please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- ❖ Have you had to hire anyone to help you with your responsibilities? \_\_\_\_\_

\_\_\_\_\_

Who has helped you and in what way? \_\_\_\_\_

\_\_\_\_\_

- ❖ Have you ever been in another motor vehicle accident? If yes, when and please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- ❖ What do you expect the final outcome of your treatment to be? \_\_\_\_\_

\_\_\_\_\_