McBroom Chiropractic
Motor Vehicle Accident History

PATIENT INFORMATION

PATIENT NAME:		DATE:	
ADDRESS:	CITY:		STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? ❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT
NUMBER OF PEOPLE IN THE CAR:		NAMES OF PEOPLE IN THE CAR WITH YOU:
WHAT DIRECTION WAS YOUR CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		ON WHAT STEET WERE YOU HEADED?
WHAT DIRECTION WAS THE OTHER CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		WERE YOU STRUCK FROM: ❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE
WERE YOU KNOCKED UNCONSCIOUS? ❑ YES ❑ NO		DID YOU HIT YOUR HEAD? ❑ YES ❑ NO
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?		BY AMBULANCE: ❑ YES ❑ NO
WERE THE POLICE ON THE SCENE? ❑ YES ❑ NO	WAS A REPORT FILED? ❑ YES ❑ NO	DO YOU HAVE A COPY? ❑ YES ❑ NO
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? ❑ YES ❑ NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: ❑ IMPROVING ❑ GETTING WORSE ❑ GETTING BETTER
HAVE YOU LOST TIME FROM WORK? ❑ YES ❑ NO	DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:

Insurance Information

Auto Insurance Company Name:	
Adjuster Name:	Adjuster Phone Number:
Policy Number:	Claim Number:

Accident Information

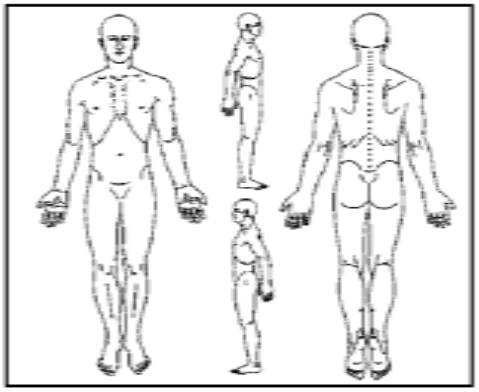
Describe the Accident in your own words:

INSTRUCTIONS: *Check (✓) any/all symptoms noted after the accident.*

❑ HEADACHE	❑ FEVER	❑ LOSS OF MEMORY
❑ NECK PAIN	❑ DIZZINESS	❑ EARS RING
❑ NECK STIFFNESS	❑ HEAD SEEMS HEAVY	❑ FACE FLUSHED
❑ SLEEPING PROBLEMS	❑ PINS & NEEDLES IN ARMS	❑ BUZZING IN EARS
❑ BACK PAIN	❑ PINS & NEEDLES IN LEGS	❑ LOSS OF BALANCE
❑ NERVOUSNESS	❑ NUMBNESS IN FINGERS	❑ FAINTING
❑ TENSION	❑ NUMBNESS IN TOES	❑ LOSS OF SMELL
❑ IRRITABILITY	❑ SHORTNESS OF BREATH	❑ LOSS OF TASTE
❑ CHEST PAIN	❑ FATIGUE	❑ UPSET STOMACH
❑ DIARRHEA	❑ DEPRESSION	❑ OTHER: _____
❑ CONSTIPATION	❑ FEET FEEL COLD	❑ OTHER: _____
	❑ HANDS FEEL COLD	
	❑ COLD SWEATS	
	❑ LIGHT BOTHERS EYES	

INTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

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PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

Signature

Signature:	Date: