TENPENNY
Chiropractic Associates
Wellness awaits you...

100 Burnsed Place Suite# 1020
Oviedo, Florida 32765
(407)-971-3898

# CONFIDENTIAL AUTO ACCIDENT HEALTH HISTORY FORM

***Accident Information:***

Patient's Full Name: _____ Birth Date: ___/___/_____

Today's Date: _____ Date of Accident: _____

Are you being represented by an attorney? Y/N If yes, Attorney Name: _____
Attorney Phone #:_____

**Cause of Accident:** automobile vs. automobile / automobile vs. object / automobile vs. motorcycle or bike / motorcycle or bike vs. object / automobile vs. pedestrian

*I was traveling in a vehicle:* Year _____ Make _____ Model _____

*My vehicle was a:* small size car/ midsize car/ large size car / motorcycle / bicycle

*The other vehicle was a*: small size car/ midsize car/ large size car / motorcycle / bicycle

**Mechanism of Injury:**

*My vehicle was:* at a traffic light / at a stop sign / going straight / making a left turn / making a right turn / backing up / merging into traffic / stopped for traffic ahead

*The other vehicle:* hit me in the rear / hit me in the front / hit me on the side

*The other vehicle was:* running a light / merging into traffic / crossing lanes / driving straight / backing up / other: _____

*My position in the vehicle was:* driver / front seat passenger / rear right side passenger / rear left side passenger / rear middle seat passenger

*At the time of collision were you restrained with a seatbelt?* □ Yes □ No □ Uncertain

*Did the airbag deploy?* □ Yes □ No

*What position was your headrest in relative to the head?* □ Low □ Mid □ High □ There was no headrest

*At the time of the accident my head was looking:* □ Straight ahead □ To the right □ To the left

□ Up □ Down □ Other _____

*Did your head hit the headrest?* □ Yes □ No

*Did any part of your body hit the interior of the car?* □ Yes □ No If yes, explain _____

*Did you receive an injury to the head?* □ Yes □ No

*Did you lose consciousness?* □ Yes □ No

TENPENNY
Chiropractic Associates
Wellness awaits you...

100 Burnsed Place Suite# 1020
Oviedo, Florida 32765
(407)-971-3898

*What was the estimated speed of your vehicle at the time of collision?*

□ 0 MPH □ Less than 15 MPH □ Between 15-25 MPH □ Between 25-40 MPH □ Between 40-65 MPH

□ Greater than 65 MPH

*What was the estimated speed of the other vehicle in the collision?*

□ 0 MPH □ Less than 15 MPH □ Between 15-25 MPH □ Between 25-40 MPH □ Between 40-65 MPH

□ Greater than 65 MPH

*What was the estimated damage of your car?*

□ Slight damage □ Moderate damage □ Heavy damage □ Totaled □ No visible damage □ Unknown

*What was the estimated damage of the other car involved in the collision?*

□ Slight damage □ Moderate damage □ Heavy damage □ Totaled □ No visible damage □ Unknown

*Was your vehicle towed from the scene?* □ Yes □ No

*Were the police called to the scene?* □ Yes □ No

*Was there an accident report written?* □ Yes □ No

*Was emergency services called to the scene (ambulance)?* □ Yes □ No

*After the accident did you:* □ Drove home □ Arranged for a ride home □ Was driven to the hospital

□ Was transported to hospital by ambulance □ Continued with activities

*After the accident did you receive any treatment?*

□ Yes □ No If yes, check which of the following applies:

□ Admitted to the hospital □ Examined □ X-ray □ MRI □ CT □ Referred to another physician

□ Prescribed medication □ Other _____

*At the time of the accident how many people were in the car with you*: _____

*Names of occupants:*

_____

_____

_____

_____

TENPENNY
Chiropractic Associates
Wellness awaits you...

100 Burnsed Place Suite# 1020
Oviedo, Florida 32765
(407)-971-3898

***Injury Information:***

*As a result of the accident I felt my symptoms:*

□ Immediately □ Within one hour □ Within 6 hours □ During the night □ Next Morning □ Next Day

□ Other _____

*As a result of the accident I felt the following: (Check all that applies)*

□ Headaches □ Neck pain □ Upper back pain □ Low back pain □ Chest pain □ Stomach Pain

□ Wrist pain □ Elbow pain □ Knee pain □ Foot pain □ Ankle pain □ Numbness/Tingling in arms

□ Numbness/Tingling in legs □ Blurred Vision □ Other _____

*Since the accident do you feel:*

□ Worse □ Improvement □ No change □ Other _____

**IF YOU HAVE ANY RECORDS SINCE THE ACCIDENT INCLUDING BUT NOT LIMITED TO: X-RAYS, MRI, CT SCAN, ETC. PLEASE INFORM THE FRONT DESK STAFF PRIOR TO APPOINTMENT SO THEY CAN COPY RECORDS INTO YOUR CHART.**

**Please include any additional information about the accident:

_____
_____
_____
_____
_____
_____
_____
_____