Durham Family Chiropractic
Dr. Stephen M. Wrinn

Automobile Accident Information

Patient Name:_____ Date of Birth:_____ Date:_____

Dominant Hand: □ Right □ Left □ Both

Description of Accident: _____

_____

_____

During and After Accident Details: _____

_____

_____

_____

Your Vehicle Type: □ Car □ SUV □ Van □ Bus □ Large Truck □ Pickup Truck □ Other _____

Your Position in Vehicle: □ Driver □ Front Passenger □ L. Rear Passenger □ R. Rear Passenger □ Other_____

Time of Accident: _____ **Your Speed:** _____ **Their Speed:** _____

Damage to your Vehicle: □ Mild □ Moderate □ Totaled **Visibility at the Time:** □ Good □ Fair □ Poor

What was your Vehicle Doing at the Time of Accident? □ Stopped at intersection □ Stopped in traffic □ Accelerating □ Stopped at a light □ Making a Right Turn □ Making a Left Turn □ Proceeding Along □ Slowing Down □ Parking Other:_____

Road Conditions: □ Icy □ Wet □ Sandy □ Dark □ Clean& dry

Point of Impact: □ Head-On □ Rear-End □ Left Front □ Right Front □ Left Rear □ Right Rear □ Other _____

Who hit who? □ You hit other vehicle (and/ or other object _____) □ Other vehicle hit you

Your Body Position:

Did you see the accident coming? □ Yes □ No

Were you braced for the impact? □ Yes □ No

Did you have a seat belt on? □ Yes □ No

Did you have a shoulder harness on? □ Yes □ No

Did the driver's front air bag deploy? □ Yes □ No

Did the passenger front air bag deploy? □ Yes □ No

Did the side air bags deploy? □ Yes □ No

Does your vehicle have headrests? □ Yes □ No

Headrest Position? □ Even with top of head □ Even with bottom of head □ Even with middle of neck

What was the direction of your head at the time? □ Facing forward □ Turned to the right □ Turned to the left

Did your body strike the inside of your vehicle? □ Yes □ No If yes please describe_____

Did you lose consciousness during the injury? □ Yes □ No If yes for how long? _____

Your vehicle's estimated damage: _____ Damage to their vehicle □ Mild □ Moderate □ Severe

Did police show up at the scene? □ Yes □ No **Was an accident report filled out?** □ Yes □ No

Where did you go after the accident? □ Home □ Hospital ER □ Work □ Private doctor

How did you get there? □ Drove self □ Ambulance □ Someone else □ Police

X-rays/MRI done? □ Yes □ No What body parts? _____ **What did the imaging report reveal?**_____

Lab work done? □ Yes □ No What lab work?_____

Treatments: □ Cervical Collar □ Ice □ Other: _____

Medications: _____

Follow up instructions: _____

_____

Check off the symptoms right after and a few days following the accident.

□ Headache □ Loss of smell □ Tension □ Loss of taste □ Diarrhea □ Neck Pain □ Dizziness □ Irritability □ Toe numbness □ Depression □ Neck stiffness □ Nausea □ Mid back pain □ Constipation □ Anxious □ Fainting □ Confusion □ Low back pain □ Cold Hands □ Chest pain □ Ringing in ears □ Fatigue □ Nervousness □ Cold feet □ Pain behind eyes □ Shortness of breath □ Sleep issues □ Other: _____

Prior Similar Symptoms:

□ I have NOT had prior similar symptoms to current complaints.

□ My current complaints DID exist before, but had been dormant.

□ My current complaints ALREADY existed and were worsened.

Current Complaints

PRIMARY COMPLAINT (CHECK ONLY 1 COMPLAINT AND ANSWER QUESTIONS FOR THIS COMPLAINT ONLY):

□ **Headaches** (□ Left □ Right □ Both) □ Front of head □ Top and/or sides □ Back of Head

□ **Jaw** □ Left □ Right □ Both

□ **Eye** □ Left □ Right □ Both

□ **Neck** □ Left □ Right □ Both

□ **Upper Back** □ Left □ Right □ Both

□ **Mid Back** □ Left □ Right □ Both

□ **Low Back** □ Left □ Right □ Both

□ **Chest** □ Left □ Right □ Both

□ **Abdomen** □ Left □ Right □ Both

□ **Ribs** □ Left □ Right □ Both

□ **Buttocks** □ Left □ Right □ Both

□ **Shoulder** □ Left □ Right □ Both

□ **Upper Arm** □ Left □ Right □ Both

□ **Forearm** □ Left □ Right □ Both

□ **Hand** □ Left □ Right □ Both

□ **Hip** □ Left □ Right □ Both

□ **Leg** □ Left □ Right □ Both

□ **Foot** □ Left □ Right □ Both

□ **Other:**_____

Types of Pain:

□ Dull □ Throbbing □ Numbing □ Shooting □ Spasm □ Cutting □ Sharp □ Tingling □ Burning □ Pounding □ Stinging □ Cramping □ Aching □ Constricting □ Other:_____

Does this Pain Radiate?

□ **Head** □ Left □ Right □ Both

□ **Neck** □ Left □ Right □ Both

□ **Shoulder** □ Left □ Right □ Both

□ **Arm** □ Left □ Right □ Both

□ **Hand** □ Left □ Right □ Both

□ **Hip** □ Left □ Right □ Both

□ **Leg** □ Left □ Right □ Both

□ **Foot** □ Left □ Right □ Both

Actions Affecting Pain (B= Brings on, A= Aggravates, R= Relieves)

□ **In the AM** □ B □ A □ R

□ **In the PM** □ B □ A □ R

□ **Bending Forward** □ B □ A □ R

□ **Bending Back** □ B □ A □ R

□ **Bending Left** □ B □ A □ R

□ **Bending Right** □ B □ A □ R

□ **Twisting Left** □ B □ A □ R

□ **Twisting Right** □ B □ A □ R

□ **Cough** □ B □ A □ R

□ **Sneezing** □ B □ A □ R

□ **Straining** □ B □ A □ R

□ **Standing** □ B □ A □ R

□ **Sitting** □ B □ A □ R

□ **Lifting** □ B □ A □ R

□ **Other:**_____ □ B □ A □ R

□ **Other:**_____ □ B □ A □ R

□ **Other:**_____ □ B □ A □ R

□ **Other:**_____ □ B □ A □ R

Pain Frequency:

□ Up to ¼ of awake time

□ ¼ to ½ of awake time

□ ½ to ¾ of awake time

□ Most all the time

Pain Intensity:

□ Doesn't affect daily activities

□ Somewhat affect activities

□ Seriously affects activities

□ Prevents activities

SECONDARY COMPLAINT (SKIP THIS SECTION IF YOU DO NOT HAVE A SECONDARY COMPLAINT)

(CHECK ONLY 1 COMPLAINT AND ANSWER QUESTIONS FOR THIS COMPLAINT ONLY):

□ **Headaches** (□ Left □ Right □ Both) □ Front of head □ Top and/or sides □ Back of Head

□ **Jaw** □ Left □ Right □ Both
□ **Eye** □ Left □ Right □ Both
□ **Neck** □ Left □ Right □ Both
□ **Upper Back** □ Left □ Right □ Both
□ **Mid Back** □ Left □ Right □ Both
□ **Low Back** □ Left □ Right □ Both
□ **Chest** □ Left □ Right □ Both
□ **Abdomen** □ Left □ Right □ Both
□ **Ribs** □ Left □ Right □ Both

□ **Buttocks** □ Left □ Right □ Both
□ **Shoulder** □ Left □ Right □ Both
□ **Upper Arm** □ Left □ Right □ Both
□ **Forearm** □ Left □ Right □ Both
□ **Hand** □ Left □ Right □ Both
□ **Hip** □ Left □ Right □ Both
□ **Leg** □ Left □ Right □ Both
□ **Foot** □ Left □ Right □ Both
□ **Other:**_____

Types of Pain:

□ Dull □ Throbbing □ Numbing □ Shooting □ Spasm □ Cutting □ Sharp □ Tingling □ Burning □ Pounding
□ Stinging □ Cramping □ Aching □ Constricting □ Other:_____

Does this Pain Radiate?

□ **Head** □ Left □ Right □ Both
□ **Neck** □ Left □ Right □ Both
□ **Shoulder** □ Left □ Right □ Both
□ **Arm** □ Left □ Right □ Both

□ **Hand** □ Left □ Right □ Both
□ **Hip** □ Left □ Right □ Both
□ **Leg** □ Left □ Right □ Both
□ **Foot** □ Left □ Right □ Both

Actions Affecting Pain (B= Brings on, A= Aggravates, R= Relieves)

□ **In the AM** □ B □ A □ R
□ **In the PM** □ B □ A □ R
□ **Bending Forward** □ B □ A □ R
□ **Bending Back** □ B □ A □ R
□ **Bending Left** □ B □ A □ R
□ **Bending Right** □ B □ A □ R
□ **Twisting Left** □ B □ A □ R
□ **Twisting Right** □ B □ A □ R
□ **Cough** □ B □ A □ R

□ **Sneezing** □ B □ A □ R
□ **Straining** □ B □ A □ R
□ **Standing** □ B □ A □ R
□ **Sitting** □ B □ A □ R
□ **Lifting** □ B □ A □ R
□ **Other:**_____ □ B □ A □ R
□ **Other:**_____ □ B □ A □ R
□ **Other:**_____ □ B □ A □ R
□ **Other:**_____ □ B □ A □ R

Pain Frequency:

□ Up to ¼ of awake time
□ ¼ to ½ of awake time
□ ½ to ¾ of awake time
□ Most all the time

Pain Intensity:

□ Doesn't affect daily activities
□ Somewhat affect activities
□ Seriously affects activities
□ Prevents activities

TERTIARY COMPLAINT (SKIP THIS SECTION IF YOU DO NOT HAVE A TERTIARY COMPLAINT)

(CHECK ONLY 1 COMPLAINT AND ANSWER QUESTIONS FOR THIS COMPLAINT ONLY):

□ **Headaches** (□ Left □ Right □ Both) □ Front of head □ Top and/or sides □ Back of Head

□ **Jaw** □ Left □ Right □ Both
□ **Eye** □ Left □ Right □ Both
□ **Neck** □ Left □ Right □ Both
□ **Upper Back** □ Left □ Right □ Both
□ **Mid Back** □ Left □ Right □ Both
□ **Low Back** □ Left □ Right □ Both
□ **Chest** □ Left □ Right □ Both
□ **Abdomen** □ Left □ Right □ Both
□ **Ribs** □ Left □ Right □ Both
□ **Buttocks** □ Left □ Right □ Both
□ **Shoulder** □ Left □ Right □ Both
□ **Upper Arm** □ Left □ Right □ Both
□ **Forearm** □ Left □ Right □ Both
□ **Hand** □ Left □ Right □ Both
□ **Hip** □ Left □ Right □ Both
□ **Leg** □ Left □ Right □ Both
□ **Foot** □ Left □ Right □ Both
□ **Other:**_____

Types of Pain:

□ Dull □ Throbbing □ Numbing □ Shooting □ Spasm □ Cutting □ Sharp □ Tingling □ Burning □ Pounding
□ Stinging □ Cramping □ Aching □ Constricting □ Other:_____

Does this Pain Radiate?

□ **Head** □ Left □ Right □ Both
□ **Neck** □ Left □ Right □ Both
□ **Shoulder** □ Left □ Right □ Both
□ **Arm** □ Left □ Right □ Both
□ **Hand** □ Left □ Right □ Both
□ **Hip** □ Left □ Right □ Both
□ **Leg** □ Left □ Right □ Both
□ **Foot** □ Left □ Right □ Both

Actions Affecting Pain (B= Brings on, A= Aggravates, R= Relieves)

□ **In the AM** □ B □ A □ R
□ **In the PM** □ B □ A □ R
□ **Bending Forward** □ B □ A □ R
□ **Bending Back** □ B □ A □ R
□ **Bending Left** □ B □ A □ R
□ **Bending Right** □ B □ A □ R
□ **Twisting Left** □ B □ A □ R
□ **Twisting Right** □ B □ A □ R
□ **Cough** □ B □ A □ R
□ **Sneezing** □ B □ A □ R
□ **Straining** □ B □ A □ R
□ **Standing** □ B □ A □ R
□ **Sitting** □ B □ A □ R
□ **Lifting** □ B □ A □ R
□ **Other:**_____ □ B □ A □ R
□ **Other:**_____ □ B □ A □ R
□ **Other:**_____ □ B □ A □ R
□ **Other:**_____ □ B □ A □ R

Pain Frequency:

□ Up to ¼ of awake time
□ ¼ to ½ of awake time
□ ½ to ¾ of awake time
□ Most all the time

Pain Intensity:

□ Doesn't affect daily activities
□ Somewhat affect activities
□ Seriously affects activities
□ Prevents activities

Activities of Daily Living

Place a check under the applicable level of functionality to the right for each activity of daily living that applies to you	Five Levels of Functionality				
	Can be performed without any difficulty	Can be performed without much difficulty, despite some pain	Can be managed by yourself despite marked pain	Can be managed, despite the pain, but only with assistance	Cannot be performed at all, because of the pain
SELF CARE AND PERSONAL HYGIENE					
Bathing					
Drying Hair					
Brushing Teeth					
Putting on Shoes					
Preparing Meals					
Taking out the Trash					
Showering					
Combing Hair					
Making the Bed					
Tying Shoes					
Eating					
Doing Laundry					
Washing Hair					
Washing Face					
Putting on a Shirt					
Putting on Pants					
Cleaning Dishes					
Going to the Toilet					
PHYSICAL ACTIVITIES					
Standing					
Standing for Long Periods					
Walking					
Walking for Long Periods					
Kneeling					
Kneeling for Long Periods					
Sitting					
Sitting for Long Periods					
Stooping					
Reaching					
Reclining					
Squatting					
Bending Back					

Place a check under the applicable level of functionality to the right for each activity of daily living that applies to you	Five Levels of Functionality				
	Can be performed without any difficulty	Can be performed without much difficulty, despite some pain	Can be managed by yourself despite marked pain	Can be managed, despite the pain, but only with assistance	Cannot be performed at all, because of the pain
PHYSICAL ACTIVITIES CONTINUED					
Bending Left					
Bending Right					
Bending Forward					
Leaning Back					
Leaning Left					
Leaning Right					
Leaning Forward					
Twisting Left					
Twisting Right					
FUNCTIONAL ACTIVITIES					
Carrying Small Objects					
Carrying Large Objects					
Carrying a Briefcase					
Carrying a Large Purse					
Lifting Weights off the Floor					
Lifting Weights off the Table					
Pushing Things While Seated					
Pushing Things While Standing					
Pulling Things While Seated					
Pulling Things While Standing					
Exercising Upper Body					
Exercising Lower Body					
Exercising Arms					
Exercising Legs					
Climbing Stairs					
Climbing Inclines					
SOCIAL AND RECREATIONAL ACTIVITIES					
Bowling					
Jogging					
Swimming					
Ice Skating					
Competitive Sports					
Dating					
Golfing					
Dancing					
Skiing					
Hobbies					
Dining Out					

Place a check under the applicable level of functionality to the right for each activity of daily living that applies to you	Five Levels of Functionality				
	Can be performed without any difficulty	Can be performed without much difficulty, despite some pain	Can be managed by yourself despite marked pain	Can be managed, despite the pain, but only with assistance	Cannot be performed at all, because of the pain
DIFFICULTIES WITH TRAVELING					
Driving a Motor Vehicle					
Driving for Long Periods					
As a Passenger in a Car					
As a Passenger in a Train					
As a Passenger on a Plane					
As a Passenger for Long Periods					
Place a check under the applicable level of functionality to the right for each activity of daily living that applies to you	Five Levels of Functionality				
	This area is not being affected by my condition	This area is being slightly affected by my condition	My condition moderately restricts my ability in this area	My condition seriously limits my ability in this area	My condition prevents me from using this ability
DIFFICULTIES WITH COMMUNITCATING					
Concentrating					
Listening					
Speaking					
Reading					
Writing					
Typing					
DIFFICULTIES WITH THE SENSES					
Seeing					
Hearing					
Sense of Touch					
Sense of Taste					
Sense of Smell					
DIFFICULTIES WITH HAND FUNCTIONS					
Grasping					
Holding					
Pinching					
Percussive Movements					
Sensory Discrimination					
DIFFICULTIES WITH SLEEP AND OTHER FUNCTIONS					
Getting a Normal, Restful Night's Sleep					
Participating in Sexual Activity					
Desire to participate in Sexual Activity					
Participating in Social Activities					
Desire to participate in Social Activities					

Signature of Patient:_____ Date:_____