Clemens Chiropractic & Rehabilitation Clinic
Accident History Questionnaire

Personal Injury Patient History

Name:_____ Date:_____

1. Date of Accident:_____ 2. Time:_____
3. Driver of Car:_____ 4. Where were you seated? :_____
5. Where was the car struck? (Please try to illustrate)

front of car rear of car

front of car rear of car

6. Please describe the accident:_____
   _____
   _____
7. At the time of accident, recall what parts of your head or body hit what parts on the inside of the car:_____
8. Did you see the accident coming? ☐ Yes ☐ No
9. Did you brace for impact? ☐ Yes ☐ No
10. Were seatbelts worn? ☐ Yes ☐ No
11. Were shoulder harnesses worn? ☐ Yes ☐ No
12. Does your car have headrests? ☐ Yes ☐ No
13. If yes, what was the position of those headrests compared to your head before the accident? ☐ Top of headrest even with **bottom** of head
    ☐ Top of headrest even with **top** of head
    ☐ Top of headrest even with **middle** of neck
14. Was your car braking? ☐ Yes ☐ No 14. Was your car moving? ☐ Yes ☐ No
15. If you were moving, how fast:_____mph
16. How fast would you estimate the other car was moving?_____mph
17. Head/Body position at the time of impact:
    ☐ Head turned left/right ☐ Body straight in sitting position
    ☐ Head looking back ☐ Body rotated right/left
    ☐ Head straight forward ☐ Other:
18. As a result of the accident were you: ☐ Rendered unconscious ☐ In shock
    ☐ Dazed, circumstances vague ☐ other:
19. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
20. Could you move all parts of your body? ☐ Yes ☐ No
21. If you answered ***NO*** to #20, what parts couldn't you move and why?
    _____
22. Where you able to get out of the car & walk unaided? ☐ Yes ☐ No
23. If NO, why not? _____

24. Did you get any bleeding cuts? ☐ Yes ☐ No If Yes, where? _____
25. Did you get any bruises? ☐ Yes ☐ No If Yes, where? _____
26. Please describe how you felt;
    a. Immediately after the accident:_____
    b. Later that day:_____
    c. The next day: _____
27. Check the symptoms apparent since the accident:

☐ Headache	☐ Neck pain/stiffness	☐ Mid back pain
☐ Eye light sensitive	☐ Pain behind eyes	☐ Dizziness
☐ Fainting	☐ Sleeping problems	☐ Numbness in fingers
☐ Numbness in toes	☐ Loss of smell	☐ Loss of taste
☐ Loss of memory	☐ Fatigue	☐ Breath shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of balance	☐ Tension	☐ Cold hands
☐ Cold feet	☐ Diarrhea	☐ Constipation
☐ Chest Pain	☐ Nervousness	☐ Cold sweats
☐ Anxious	☐ Facial Pain	☐ Jaw clicking/popping
☐ Low back pain	☐ Other: _____	

28. Occupation: _____
29. Employer: _____
30. Have you missed time from work? ☐ Yes ☐ No
31. If Yes, full time off work: _____ to _____
32. If Yes, part time off work: _____ to _____
33. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
34. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Self
    ☐Somebody else drove me ☐ other: _____
35. Doctor #1: Name: _____
36. First Visit Date: _____
37. Were you examined? ☐ Yes ☐ No
38. Were x-rays taken? ☐ Yes ☐ No
39. Did you receive treatment? ☐ Yes ☐ No ☐ Medication ☐ Braces ☐ collars
40. What benefits did you receive from treatment?
41. Date of last treatment:_____
42. Doctor #2: Name:_____
43. First Visit Date: _____
44. Were you examined? ☐ Yes ☐ No
45. Were x-rays taken? ☐ Yes ☐ No
46. Did you receive treatment? ☐ Yes ☐ No ☐ Medication ☐ Braces ☐ collars
47. What benefits did you receive from treatment? _____
48. Date of last treatment:_____
49. Do you have an attorney on this claim? ☐ Yes ☐ No
50. If yes, who? _____
    a. Address:_____
    b. City:_____State:_____Zip:_____
    c. Phone:_____

Nervous System

☐ Numbness	☐ Loss of feeling	☐ Paralysis
☐ Dizziness	☐ Fainting	☐ Headaches
☐ Muscle jerking	☐ Convulsions	☐ Forgetfulness
☐ Confusion	☐ Depression	

Cardio-Vascular System

☐ Chest Pain	☐ Pain over heart	☐ Difficult Breathing
☐ Persistent Cough	☐ Coughing phlegm	☐ Coughing Blood
☐ Rapid Heartbeat	☐ High Blood Pressure	☐ Heart Problems
☐ Lung problems	☐ Varicose veins	☐ Other

Eye, Ear, Nose and Throat System

☐ Eye Inflammation	☐ Vision Problems	☐ Eye strain
☐ Ear Pain	☐ Ear noises	☐ Ear discharge
☐ Hearing loss	☐ Nose pain	☐ Nose bleeding
☐ Nose discharge	☐ Breathing difficulty	☐ Sore gums
☐ Sore mouth	☐ Sore throat	☐ Hoarseness
☐ Speech difficulty	☐ Dental problems	

Thank you for completing this form!

_____

Patient Signature

CLEMENS CHIROPRACTIC & REHABILITATION CLINIC

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Greensburg, PA 15601
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Terry L. Clemens, D.C., C.S.C.S.

Consent to Treat Minor

Patient Name: _____

I hereby request and authorize Clemens Chiropractic & Rehabilitation Clinic to perform any diagnostic tests and render chiropractic treatments and other treatments to my minor son/daughter _____.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize the care should be revoked, or modified in any way, I will immediately notify this office.

Date: _____

_____
Signature

_____
Witness

_____
Printed name

_____
Relationship to Patient