Tuttle DeLucchi
Chiropractic & Massage

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ACCIDENT HISTORY FORM

Patient Name_____ Date:_____

Date of Accident:_____ Time:_____AM/PM

Location of Accident:_____

Driver of vehicle:_____

Passengers:_____

Who owns the vehicle?:_____

Year/Model of vehicle:_____

Year/Model of other vehicle(s) involved:_____

Approx, Damage done to vehicle: $_____

Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other:_____

Road conditions: ☐ dry ☐ wet ☐ icy ☐ loose gravel ☐ other: _____

Weather conditions: ☐ clear ☐ overcast ☐ rain ☐ snow ☐ other:_____

In your own words describe what happened:

_____

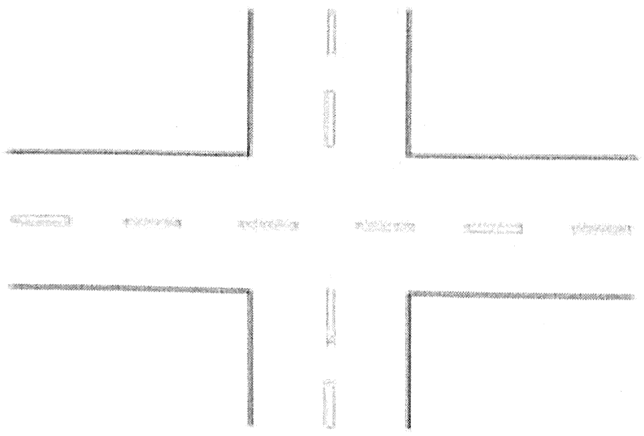
_____

_____

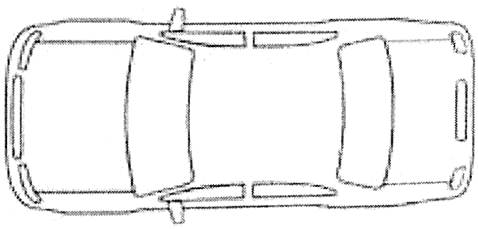
_____

_____

Draw a diagram of the accident:



Where was your vehicle struck?



Accident Details:

Type of accident: ☐ head on collision ☐ broadside collision ☐ front impact ☐rear-end ☐ non-collision

☐Yes ☐No Was your vehicle braking?

☐Yes ☐No Was your vehicle moving at the time of the accident?

How fast were you going?:_____

How fast was the other vehicle going?:_____

☐Yes ☐No Did you see the accident coming?

☐Yes ☐No Did you brace for impact?

☐Yes ☐No Were seat belts worn?

☐Yes ☐No Airbags deploy?

At the time of the accident, do you recall if any parts of your body struck any aspect of the vehicle (i.e. steering wheel, door, window), if so what body part(s) and where did it strike?:_____

Head/body position at time of impact:

☐ head turned left/right ☐ head looking back over shoulder left/right

☐ body strait ☐ body rotated left/right ☐ other: _____

What was the position of the headrests compared to your head before the accident?

Top of headrest at: ☐ Top of head ☐ Middle of head ☐ Bottom of head ☐ No Headrest

As result of accident were you:

☐ rendered unconscious ☐ in shock ☐ dazed/confused ☐ other:_____

☐Yes ☐No Able to get out of the vehicle unaided?

☐Yes ☐No Any cuts/bleeding?

☐Yes ☐No Any bruising?

☐Yes ☐No Could you move all the parts of your body?

If no, what parts couldn't you move and why?:_____

Describe how you felt:

Immediately after the accident: _____

Later that day (a few hours after): _____

The next day (any new symptoms or change in severity?):_____

Since the accident:

☐Yes ☐No Any physical conditions/complaints before and not related to the accident?

If yes, please describe:_____

☐Yes ☐No Did you seek medical help immediately after the accident?

If yes, who did you see and what did they recommend?: _____

☐Yes ☐No X-rays taken?

☐Yes ☐No Were you examined/receive treatment?

Treatment rendered:_____

☐Yes ☐No Medications: _____

☐Yes ☐No Braces: back brace, neck collar, arm sling, etc...

☐Yes ☐No Have you missed time from work?

How much time have you lost? _____to_____

☐Yes ☐No Do you have an attorney on this claim?

Who:_____

Please List things that you have trouble with since the accident:(washing hair, getting into car, focusing at work etc...)

Clinician Signature:_____

Patient Name:_____

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This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by **drawing a circle around the number that corresponds with the one statement** that applies to you. If two or more statements in one section apply, please circle the number of the one statement that most closely describes your problem.

Pain Intensity

0 • The pain comes and goes and is very mild.
1 • The pain is mild and does not vary much.
2 • The pain comes and goes and is moderate.
3 • The pain is moderate and does not vary much.
4 • The pain comes and goes and is very severe.
5 • The pain is very severe and does not vary much.

Sleeping

0 • I get no pain in bed.
1 • I get pain in bed but it does not prevent me from sleeping well.
2 • Because of pain my normal sleep is reduced by less than 25%.
3 • Because of pain my normal sleep is reduced by less than 50%.
4 • Because of pain my normal sleep is reduced by less than 75%.
5 • Pain prevents me from sleeping at all.

Sitting

0 • I can sit in any chair as long as I like.
1 • I can only sit in my favorite chair as long as I like.
2 • Pain prevents me from sitting more than 1 hour.
3 • Pain prevents me from sitting more than ½ hour.
4 • Pain prevents me from sitting more than 10 minutes.
5 • I avoid sitting because it increases pain immediately.

Standing

0 • I can stand as long as I want without pain.
1 • I have some pain while standing but it does not increase with time.
2 • I cannot stand for longer than 1 hour without increasing pain.
3 • I cannot stand for longer than ½ hour without increasing pain.
4 • I cannot stand for longer than 10 minutes without increasing pain.
5 • I avoid standing because it increases pain immediately.

Personal Care

0 • I do not have to change my way of washing or dressing in order to avoid pain.
1 • I do not normally change my way of washing or dressing even though it causes some pain.
2 • Washing and dressing increases the pain but I manage not to change my way of doing it.
3 • Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4 • Because of the pain I am unable to do some washing and dressing without help.
5 • Because of the pain I am unable to do any washing and dressing without help.

Walking

0 • I have no pain while walking.
1 • I have some pain while walking but it doesn't increase with distance.
2 • I cannot walk more than 1 mile without increasing pain.
3 • I cannot walk more than ½ mile without increasing pain.
4 • I cannot walk more than ¼ mile without increasing pain.
5 • I cannot walk at all without increasing pain.

Lifting

0 • I can lift heavy weights without extra pain.
1 • I can lift heavy weights but it causes extra pain.
2 • Pain prevents me from lifting heavy weights off the floor.
3 • Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
4 • Pain prevents me from lifting heavy weights off the floor, but I can manage light/medium weights if they are conveniently positioned.
5 • I can only lift very light weights.

Traveling

0 • I get no pain while traveling.
1 • I get some pain while traveling but none of my usual forms of travel make it worse.
2 • I have pain while traveling but I endure it.
3 • I get extra pain while traveling which causes me to seek alternate forms of travel.
4 • Pain restricts all forms of travel except that done while lying down.
5 • Pain restricts all forms of travel.

Social Life

0 • My social life is normal and gives me no extra pain.
1 • My social life is normal but increases the degree of pain.
2 • Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
3 • Pain has restricted my social life and I do not go out very often.
4 • Pain has restricted my social life to my home.
5 • I have hardly any social life because of the pain.

Changing degree of pain

0 • My pain is rapidly getting better.
1 • My pain fluctuates but overall is definitely getting better.
2 • My pain seems to be getting better but improvement is slow.
3 • My pain is neither getting better nor worse.
4 • My pain is gradually worsening.
5 • My pain is rapidly worsening.

Clinician Signature:_____

Patient Name:_____

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