VITALE CHIROPRACTIC

Accident Information

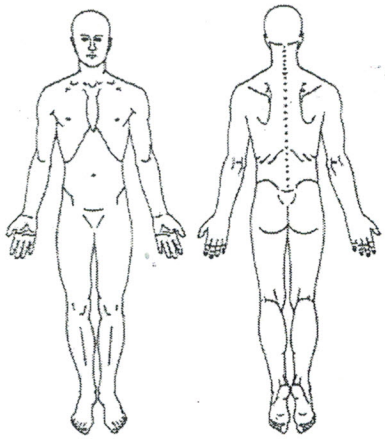
Conditions- Impact: Road conditions: wet dry rain ice snow gravel slick-oily poor visibility
Type of Collision: front rear side chain reaction hit other vehicle hit object _____

Vehicle(s): Vehicle you were in _____ parked stopped moving w/estimated speed _____ MPH
Other Vehicles involved 1)_____ 2) _____ 3) _____
Other Vehicles involved parked stopped moving with estimated speed _____ MPH
Did air bag deploy? yes no Was your vehicle drivable? yes no totaled Traffic Citation issued? yes no

Patient Positions: driver passenger: front or rear seat belted headrest (high mid low none)
Head-body position prior to impact: left right straight braced relaxed asleep foot on brake or accelerator
Any body parts hit inside of vehicle? no if yes what _____ Any passengers in your vehicle? 0 1 2 3 4

Patient Conditions ___
Immediately after the accident, were you Disoriented Unconscious, how long?_____

stiffness-muscle tension	numbness-tingling	jaw pain
headaches	nausea	dizziness
memory loss	irritability	blurred vision
chest-rib pain	breathing probs	other_____



Circle severity of pain and mark all problem areas on figures to the right
None 1 2 3 4 5 6 7 8 9 10 Excruciating
How is it changing? worse no change better Delayed onset? no if yes how
How often do you have the symptoms? constant (75-100% of day)
frequent (50-75% of day)
intermittent (25-50% of day)
occasional (Less than 25% of day)
Describe the complaint: sharp dull throbbing numbness aching shooting
burning tingling cramps stiffness swelling
other:_____
Any pain, numbness, tingling, or weakness radiating to the arms or legs? no if yes left right both
What makes it better?_____ What makes it worse?_____

Please note <u>which 2-5 activities</u> are mostly being affected by your complaints.
Sit Stand Walk Sleep Get up-down Personal care: Dress, Bathe, etc.
Lift Bend Drive Work Clean house Exercise Hobbies: _____
Yard Shop Cook Read Computer Love-Life
Tell us by circling how much these activities are affected by your condition.
No Effect 0 1 2 3 4 5 6 7 8 9 10 Unable to perform
Moderate

Exam / Treatments: EMT treated on scene no yes Transported to hosp no yes
Name of facility or doctors_____ Dates_____
Treatment performed: exam x-rays meds chiropractic PT MRI / CT surgery other:_____
Have you worked since the accident? yes no, work days missed _____
Have you had similar problems prior to this accident? no yes, explain_____
Contact Info: Insurance Co, attorney, or responsible party for payment: _____
Contact person name _____ phone _____ claim number _____

I certify the above information is correct to the best of my knowledge.

Patient or guardian signature_____ Date _____