Hoglund Chiropractic Center, P.A.
Central Brevard Medical Center
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FILL IN THE BLANK ACCIDENT HISTORY

Worker's Compensation or Automobile Accident or Independent Medical Exam

NAME: _____ DATE: _____
ADDRESS: _____
CITY/STATE: _____ ZIP: _____
HOME PHONE: _____ E-MAIL: _____
CELL PHONE: _____
WORK PHONE: _____

REFERRED TO OUR OFFICE BY: _____

_____ AUTO ACCIDENT
_____ PERSONAL INJURY
_____ WORKER'S COMPENSATION

PIP INSURANCO. _____
CLAIM NO. _____
HEALTH INS CO _____
MEMBER ID NO _____

DATE OF ACCIDENT: _____ SSN: _____
DATE OF EXAM: _____ DOB: _____
EMPLOYER: _____ OCCUPATION: _____
EMPLOYER'S ADDRESS: _____ CITY: _____
MARITAL STATUS: _____ NAME OF HUSBAND/WIFE: _____
NUMBER OF CHILDREN/AGES:
_____

HISTORY:

DESCRIPTION OF ACCIDENT:
_____
_____
_____
_____
_____

DRIVER _____ PASSENGER _____ PEDESTRIAN _____ OTHER ___

TRAVELING OR STOPPED FACING: N S E W

LOCATION OF ACCIDENT: STREET _____
CITY _____ STATE _____

HISTORY OF ACCIDENT:

___ Stopped at red light or stop sign and rear ended
___ Head on collision – other vehicle traveling in opposite direction
___ Another vehicle ran a stop sign or red light
___ Slowing down to make a stop or turn – rear ended
___ Lost control of vehicle ___ Spun Around ___ Rolled Over
___ Side swiped

HISTORY OF ACCIDENT CONTINUED:

Were you wearing your shoulder and lap restraints? ____ yes /____ no
Did vehicle have an air bag? ___ yes ___ no

Did you strike any objects inside the car? ____ yes ____ no

- **____ Steering column**
- **____ Dashboard**
- **____ Windshield**
- **____ Headrest**
- **____ Door frame**
- **____ Jarred or thrown about**
- **____ Rear View Mirror**
- **____ Seat broke**
- **____ Cannot remember details**
- **____Other: _____**

What portion of your body did you strike?
____ Head ____ Chest ____ Face ____ Knees ____ Arms Other: _____

Were you rendered unconscious, cut or bleeding? _____ yes _____ no
If cut, please explain where: _____

If patient experienced immediate pain, please indicate:

_____ Headache	**_____ Right**	**_____ Left**
_____ Neck Pain	**_____ Right**	**_____ Left**
_____ Mid-back Pain	**_____ Right**	**_____ Left**
_____ Low-back Pain	**_____ Right**	**_____ Left**
_____ Extremity	**_____ Right**	**_____ Left**
_____ Other: _____		

After the accident, did you:
_____ Go Home _____ Go about your business _____ Go to the hospital

HOSPITALIZATION:

If taken to the hospital, how? _____ Ambulance _____Drove yourself
_____ Driven by friend/relative
_____Went home and later was taken or drove to the hospital

Name of hospital taken to:
___ Wuesthoff ___ Cape Canaveral ___ Jess Parrish ___ Holmes Regional

Were you seen in the emergency room? ___ yes ___ no
Were you admitted to the hospital? ___ yes ___ no
If admitted, how long did you stay? _____
Name of admitting or hospital physician: _____
In the emergency room or hospital, what was done? _____

_____ Examination	**_____ Stitches**	**_____Physiotherapy**
_____ X-Rays	**_____ Cervical Collar**	**_____Complete bed rest**
_____Prescription	**_____Other: _____**	

After your release, what did you do?
_____ Return home to bed
_____ Return to work
_____ Return to emergency room
_____ other _____

HOSPITALIZATION CONTINUED:

When did you first consult a physician?
_____same day _____ following day _____ within a few days
_____other

_____

If patient consulted only with this office since the accident, skip to *PAST HISTORY*

Who did you consult? Dr. _____
___ Family Physician ___ Chiropractor ___ Orthopaedist ___ Osteopath

What did the doctor do?
_____ Chiropractic Manipulation _____ Examination
_____ Injections _____ X-rays
_____ Traction _____ Prescriptions
_____ Physiotherapy – If physiotherapy was administered, how long? _____
_____ other _____

Where did you receive these treatments?
_____ P.T. _____ Hospital _____ At the doctor's office

How long were you under the care of this physician? _____
Are you still under his/her care? _____ yes _____ no
Frequency or number of visits now: _____

Did the doctor refer you to or have you been to any other physicians? _____ no _____ yes
Explain _____
_____
_____

Were you sent for an additional independent medical examination? _____ no _____ yes
If yes, to whom? _____

Have you had any special testing, CT or MRI scan, EMG/NCV? _____
_____
_____

PAST HISTORY:

Previous surgery: _____
_____
_____

Previous serious disease: _____
_____

Have you had any previous fractures? _____ Yes _____ No

Have you been in any previous accident of any kind? _____ Yes _____ No
If yes, please give dates and details: _____
_____
_____

PAST HISTORY CONTINUED:

Have you ever been treated for neck or back problems by any other physicians prior to this accident?

_____ Yes _____ No If yes, please explain: _____

Current Medications: _____

DISABILITY:

Have you lost any time from work since the accident? ___ Yes ___ No
How many days? _____
Still off work? _____ Yes _____ No Date returned: _____
Job description: _____

Check your PRESENT SYMPTOMS ONLY:

( ) Weakness
( ) Vision trouble
( ) Lost urinary function
( ) Chest pain/pressure
( ) Blood in urine or stool
( ) Numbness, tingling
( ) Pain when sneezing
( ) Pain when coughing
( ) Difficulty Speaking
( ) Current infection
( ) Headaches
( ) Lost bowel function
( ) Fever
( ) Rapid weight loss
( ) Mental status change
( ) Shooting pain
( ) Loss of balance
( ) Pain with bowel
( ) Vomiting
( ) Pulsing abdomen
( ) Pain urinating
( ) Hard to swallow
( ) Back pain
( ) Paralysis
( ) Ears ring
( ) Head feels heavy
( ) Depression
( ) Fainting spells
( ) Neck pain
( ) Dizziness

Additional Comments: