Lombardi Chiropractic and Rehabilitation

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1. Name (Last, First):

2. Today's Date:

3. Date of Auto Accident:

4. Time of accident (please include AM or PM)

5. Location of accident:

6. Were you on the job at the time of the accident? Yes No

7. Is there a police report? Yes No

8. Make & model of YOUR vehicle:

9. Damage to your vehicle: Mild Moderate Totaled

10. Which parts of your vehicle were damaged?

11. Make and model of OTHER vehicle?

12. Damage to OTHER vehicle Mild Moderate Totaled

13. Did you go to the hospital? Yes No (if no, please skip to question #19)

14. Name and location of hospital:

15. How did you get to the hospital?

16. What x-rays were taken?

17. What did the hospital do for your injuries?

18. How long were you in the hospital?

19. Road conditions at the time of the accident (circle all that apply)

Dry Wet Snowed over Icy

20. What kind of visibility was there at the time of the accident? (Circle all that apply):

Clear Cloudy Foggy Rain Snow

21. Where were you seated in the vehicle at the time of the accident?

Driver Front Passenger Front Driver Side Rear Passenger Side Rear

22. Were you wearing a seat belt? Yes No (if NO, skip to question 25)

23. Did the airbag(s) deploy? Yes No

24. Were you struck by the airbag? Yes No

25. In what position were the headrests? High Middle N/A

26. If the headrests were adjustable, was the position altered by the collision? Yes No

27. Was the seat back altered by the collision? Yes No

28. Was the seat broken by the impact? Yes No

29. What was the action of YOUR vehicle at the time of impact? Circle all that apply:

Stopped at an intersection Stopped for traffic Slowing Crossing an intersection

Other: (explain) -

30. Was the driver's foot on the brake? Yes No

31. Were you aware of the impending collision? Yes No

32. Please describe the accident as you remember it. Please try to be as detailed as possible:

33. Did the vehicle strike any objects after the initial accident? If NO, skip to question 35.

Yes No

34. What did the vehicle you were in come into contact with after the initial accident? Please try to be as detailed as possible:

35. Were you wearing a hat or glasses? If NO, skip to question 37: Yes No

36. Were they displaced as a result of the accident? Yes No

37. What was your head position at the time of impact? Circle all that apply:

Straight Turned RIGHT Turned LEFT

Tilted UP Tilted DOWN Tilted LEFT Tilted RIGHT

38. What was your trunk / upper body position at the time of the accident? Circle all that apply:

Straight Turned RIGHT Turned LEFT

Tilted BACK Tilted FORWARD Tilted LEFT Tilted RIGHT

39. Did you lose consciousness? Yes No

40. Did you experience a flash of light in your head? Yes No

41. Did you strike any parts of the vehicle at the time of the accident? Yes No

*if NO, skip to question 43

42. What body parts and what part of the vehicle?

43. Did you receive any cuts or bruises? Yes No If no, skip to question 45

44. What body parts were cut or bruised and from which part of the vehicle?

45. Did you experience any of the following symptoms after the accident? Circle all that apply: (if none, skip to question 47)

Confusion Dizzy Disorientation Nauseated Light headed

Blurred vision Ringing in ears None

Other:

46. Are you still experiencing any of these symptoms? If NO, skip to question 48:

Yes No

47. Which symptom(s) are you still experiencing? Circle all that apply:

Confusion Dizzy Disorientation Nauseated Light headed

Blurred vision Ringing in ears Other:

48. Are you suffering from any of the following symptoms? Circle all that apply

Restlessness Sleeplessness Difficulty concentrating Irritability

Memory loss Forgetfulness Headaches Dizziness

Reduced tolerance to heat / cold / alcohol Tingling or numbness

Other:

49. If you do suffer from reduced tolerance, is it to: Heat Cold Alcohol

* circle all that apply

50. If you suffer from tingling or numbness, please state the location:

51. Describe your injuries. Please be as detailed as possible:

52. How would you describe your pain level? Mild Moderate Severe

53. Would you describe your pain as: (please circle all that apply)

Dull Sharp Stiff Achy Shooting

Restricted movement Often Comes and goes Throbbing

Pulsating Tender Constant Radiating Sore Frequent

54. Does the pain radiate into your arms or legs? Yes No

*please circle all that apply

Arms Legs Right Left

55. What makes the pain worse? Circle all that apply

Walking Getting out of bed Getting out of the car Standing

Standing up from a chair Climbing the stairs Other:

56. Have you missed work due to the accident? Yes No

* if no, skip to question 58

57. How much work have you missed due to the accident?

58. What helps the pain feel better? Please be as detailed as possible:

59. List all medications: