Excellence In Health Chiropractic

CAD Injury History Form

General Information:

Patient's Name: ____________________ Today's Date: ____________ Date of Injury: __________

Marital Status: ☐ M ☐ S ☐ W ☐ D

Habits:

Smoke: ☐ None Pk/day Years Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy

Employment:

At the time of the crash: __________________ Unemployed

Currently: ______________________________ ☐ Unemployed Due to crash? ☐ Yes ☐ No

Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Medical History:

Surgeries (dates and residuals):____

____

Fractures (dates and residuals): ____

____

Serious illness (dates and residuals): ____

____

W/C injuries (date, TX, awards, residuals): ____

____

Personal Injuries (date, TX, awards, residuals): ____

____

Any prior history of current complaints:

1. ______________________________
2. ______________________________
3. ______________________________

Prior treatment by D.C. for these:

1. ______________________________
2. ______________________________
3. ______________________________

Current Medical History:

Current Health Problems: ☐ None

____

____

Current Medications Taken: ☐ None

____

____

General Injury History:

Was the crash "on-the-job"? ☐ Yes ☐ No

You were: ☐ Driver ☐ Front-seat passenger ☐ Rear seat passenger ☐ Motorcycle rider ☐ Motorcycle passenger ☐ Other _________

Vehicle driven by:___________________________

Your vehicle (year, make, model): ______________

Your estimated speed at the moment of crash: __________ ☐ Stopped ☐ Slowing ☐ Accelerating

Other vehicle (year, make, model):______________

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark Road Conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other: _______

Head Restraints: ☐ None ☐ Integral type ☐ Adjustable type (circle): Up Down ☐ Don't know

** If adjustable, was the position altered by the crash? ☐ Yes ☐ No

Was the seat back adjustment altered by the crash? ☐ Yes ☐ No Was the seat broken? ☐ Yes ☐ No

Lap Belt: ☐ Wearing ☐ Not wearing ☐ Don't know Shoulder Belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know

Did air bag deploy? ☐ Yes ☐ No ** If yes, were you struck? ☐ Yes ☐ No

Body position: ☐ Good ☐ Forward lean Other: ______________________

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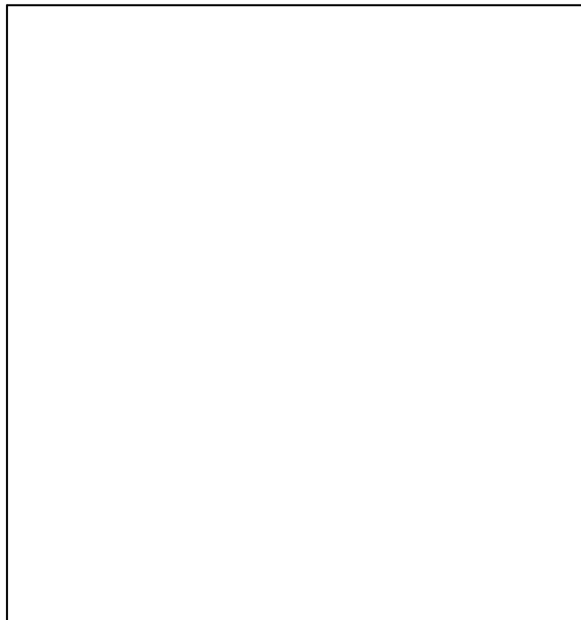
Sports or other injuries to head, neck, or back: ____________________

____

Crash description: ____________________

____

Crash Diagram:



Aware of impending crash: ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Yes ☐ No
If yes, describe: ____________________
Did vehicle strike any objects after crash?
If yes, describe: ____________________
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after the crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
If yes, for how long? ____________________
Estimated property damage to your vehicle: $ ____________________
Estimated damage to the other vehicle(s):
☐ None ☐ Minimal ☐ Moderate ☐ Major
Were the police on-scene? ☐ Yes ☐ No
If yes, was a report made? ☐ Yes ☐ No
Head position:____________________
Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A
Brakes applied? ☐ Yes ☐ No

After the Crash:

Symptoms: ☐ Headache ☐ Dizziness ☐Nausea ☐ Confusion/disorientation ☐ Neck pain
☐ Paresthesia(s) __________ ☐ Extremity pain __________ ☐ Back pain
When did SX first appear? ☐ Immediately (describe which SX) __________ hr. afterward
Where did you go after the crash? ☐ Home ☐ Work ☐ Hospital: ____________________
Mode of transportation: ____________________ Private Doctor: ____________________

Emergency department:

Radiographs: ☐ Yes ☐ No Body parts imaged: ____________________ Results: ____________________
Lab work? ☐ Yes ☐ No ☐ Cervical Collar ☐ Ice Medications: ____________________
Other: ____________________ Follow-up instructions: ☐ None ____________________

Treatment History:

1. Dr. ____________________ Specialty: ______________ Date first seen: __________
Referred by: __________ TX type: ____________ TX frequency: __________ TX duration: __________
Currently Treating: ☐ Yes ☐ No Any disability? ☐ Yes☐ No If yes, describe:____________________
Special tests: ____________________ Referred to: ____________________ Did treatment help: ☐ Yes ☐ No
Notes: ____________________

2. Dr. ____________________ Specialty: ______________ Date first seen: __________
Referred by: __________ TX type: ____________ TX frequency: __________ TX duration: __________
Currently Treating: ☐ Yes ☐ No Any disability? ☐ Yes☐ No If yes, describe:____________________
Special tests: ____________________ Referred to: ____________________ Did treatment help: ☐ Yes ☐ No
Notes: ____________________

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Original Chief Complaints (injury not recent):

1. Body part/system: ____________________________ Onset: ____
Provocation: ___________________________________ Palliative: _____________________________________
Quality: ______________________________________ Radiation: _____________________________________
Severity (1-4): __________________________________ Temporal: ______________________________________

2. Body part/system: ____________________________ Onset: ____
Provocation: ___________________________________ Palliative: _____________________________________
Quality: ______________________________________ Radiation: _____________________________________
Severity (1-4): __________________________________ Temporal: ______________________________________

3. Body part/system: ____________________________ Onset: ____
Provocation: ___________________________________ Palliative: _____________________________________
Quality: ______________________________________ Radiation: _____________________________________
Severity (1-4): __________________________________ Temporal: ______________________________________

Current Chief Complaints:

1. Body part/system: ____________________________ Onset: ____
Provocation: ___________________________________ Palliative: _____________________________________
Quality: ______________________________________ Radiation: _____________________________________
Severity (1-4): __________________________________ Temporal: ______________________________________

2. Body part/system: ____________________________ Onset: ____
Provocation: ___________________________________ Palliative: _____________________________________
Quality: ______________________________________ Radiation: _____________________________________
Severity (1-4): __________________________________ Temporal: ______________________________________

3. Body part/system: ____________________________ Onset: ____
Provocation: ___________________________________ Palliative: _____________________________________
Quality: ______________________________________ Radiation: _____________________________________
Severity (1-4): __________________________________ Temporal: ______________________________________

Self-assessment as of today: % improved (list for separate areas)

____

____

Request Records:

☐ Radiographs: _____________________________ ☐ Tomograms: _____________________________
☐ CT (areas):_________________________________ ☐ MRI (areas): ______________________________
☐ Scintigraphy/ SPECT (areas): _______________ ☐ Videofluoroscopy (areas): __________________
☐ EMG/NCV: _______________________________ ☐ SEP: _____________________________________
Root level/nerve(s): __________________ Root level/nerve(s): __________________
☐ Other electrodiagnostic test(s): ______________ ☐ Ultrasound (areas): ________________________

Action taken on this visit:

☐ Exam/treatment: ____
☐ Place on disability: _________________________ ☐ Work restriction: ____________________________________
☐ Work restriction: ____________________________ ☐ Home traction device: _______________________
☐ NEXERCICER: ____________________ ☐ Supplements: ______________________ ☐ Other: _________________________