Accident History Form - please complete as you see fit

1. Date of Accident: ___________________________________

2. Vehicle Type: _______________________________________

3. Driver/Passenger/Other: [ ] Front [ ] Rear; [ ] Left [ ] Middle [ ] Right

4. Restraints: [ ] Lap [ ] Shoulder; [ ] Airbags

5. Collision Type: [ ] Moving [ ] Stationary [ ] Turning Other _______________________

6. Unconscious/Shock/No problem ____

7. Impact within vehicle? ____

8. Able to get out of the vehicle? [ ] Yes [ ] No

9. Cuts/Abrasions/Bruises: ________________________ [ ] None

10. Onset of pain Post Accident: [ ] Immediate [ ] Delayed [ ] No Site: __________________

11. Immediate Treatment:
A. X-Ray of _________________________________ [ ] None
B. Body Part Braced __________________________ [ ] None
C. Medication taken initially ____________________ [ ] None
D. Admission to ______________________ hospital or [ ] discharged home

12. Date of first GP/Nurse Practitioner visit: ____

13. Therapy to date: ____

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Please put an "X" beside the problems below that may apply to you

[ ] Difficulty with attention/concentration, memory, word finding, multitasking or planning

[ ] Tendency to lose your train of thought or physical direction

[ ] Easily overwhelmed at home or at work or in a crowd

[ ] Concerned about speaking spontaneously in public

[ ] Hypersensitivity to noise

[ ] Difficulty following the conversations of others, or story line of a movie or T.V. show

[ ] Mood problems - such as anger, irritability, frustration, depression, anxiety, grief or being tearful

[ ] Problems with impulse control or judgment abilities

[ ] Changes in intellectual abilities

[ ] Insomnia

[ ] Fatigue

[ ] Dizziness, balance problems or in-coordination

[ ] Headache or neck pain

[ ] Decreased sense of smell, taste or touch

[ ] Decreased sexual libido

Please add any other details you feel are pertinent

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