



## Motor Vehicle Accident Information

Last Name:	First Name:	Middle:
Location of Injury (City, State):	Date of Injury:	Time:

### General Information

<b>Location</b> (circle one)	<b>Driver</b>	Location (circle one)	Front / Middle / Rear
	<b>Passenger</b>	Position (circle one)	Left / Middle / Right

### Work from Left to Right and Circle One

<b>Primary Vehicle</b>	<b>Type :</b>	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	<b>Size :</b>	Mini / Sub Comp / compact / Mid Size / Full Size
	<b>Action :</b>	Stopped / Slowing / Acceleration / Cruising <b>Speed (MPH):</b>
	<b>Time of Accident:</b>	Day Light / Dawn / Dusk / Dark
	<b>Road Condition:</b>	Dry / Damp / Wet / Snow / Ice
	<b>Visibility:</b>	Good / Fair / Poor

*Enter impact information for up to three Vehicles or Objects*

### Impact Information: Vehicle or Object (I)

(Select one) <input type="checkbox"/> <b>Vehicle</b>  <input type="checkbox"/> <b>Object</b>	<b>Name Object :</b>		
	<b>Vehicle Type :</b>	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:	
	<b>Size :</b>	Mini / Sub Comp / compact / Mid Size / Full Size	
	<b>Damage to Veh.:</b>	Minimal / Moderate / Extensive / Totaled / Unsure	
<b>Impact Location</b>			

### Impact Information: Vehicle or Object (II)

(Select one) <input type="checkbox"/> <b>Vehicle</b>  <input type="checkbox"/> <b>Object</b>	<b>Name Object :</b>		
	<b>Vehicle Type :</b>	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:	
	<b>Size :</b>	Mini / Sub Comp / compact / Mid Size / Full Size	
	<b>Damage to Veh.:</b>	Minimal / Moderate / Extensive / Totaled / Unsure	
<b>Impact Location</b>			

### Impact Information: Vehicle or Object (III)

(Select one) <input type="checkbox"/> <b>Vehicle</b>  <input type="checkbox"/> <b>Object</b>	<b>Name Object :</b>		
	<b>Vehicle Type :</b>	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:	
	<b>Size :</b>	Mini / Sub Comp / compact / Mid Size / Full Size	
	<b>Damage to Veh.:</b>	Minimal / Moderate / Extensive / Totaled / Unsure	
<b>Impact Location</b>			

### During Impact Information:

Seat Belt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brakes Applied?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Air Bag Deployed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seat Broken?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seat Back position Changed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	<input type="checkbox"/> Yes / <input type="checkbox"/> No
(Circle One)	Direction of Throw:(Circle One) Backwards/Forward/Outside/Unsure/Other
Head Position (Circle One):	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion (Circle One):	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

BACK TO BASICS CHIROPRACTIC

Robert L. Rettig, D.C. / Marshall S. Mathews, D.C. / Bryson J. Bunch, D.C. / Jerad M. Howell, D.C.  
8033 W. Grandridge Blvd. Ste. C, Kennewick, WA 99336 / 509-783-BACK (2225) / [www.back2basics.com](http://www.back2basics.com)

**Body Impact**

<input type="checkbox"/> Head	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Right hand	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Left hand	<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Left Elbow
<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Right Shoulder
<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Left Foot	<input type="checkbox"/> Left Knee	<input type="checkbox"/> Lower Front Torso	<input type="checkbox"/> Right Knee

**After Accident Information:**

Immediately After Accident:  Dizzy/dazed  Upset  Weak  Nervous  Headache  Disoriented  Unconscious  Other:

**Pain**

<input type="checkbox"/> Head	<input type="checkbox"/> Left foot	<input type="checkbox"/> Right foot	<input type="checkbox"/> Left Knee	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg
<input type="checkbox"/> Left Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right knee	<input type="checkbox"/> Upper Back	
<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right elbow	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Mid back	
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Lower Front Torso	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Other :	

**Numbness:**  Left Hand  Right Hand  Left Leg  Right Leg  Left Upper Arm  
 Right Upper Arm  Left Foot  Right Foot  Other:

**Medical Information**

Medical Care?  Yes  No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No Days Spent in Hospital:
Test:	<input type="checkbox"/> X-ray <input type="checkbox"/> Lab Work <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Other:(Specify)
Treatment:	<input type="checkbox"/> Ice Pack <input type="checkbox"/> Hot Pack <input type="checkbox"/> None <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Medication <input type="checkbox"/> Other:(Specify)

**Previous Injuries**

Previous Injuries / Accidents  No  Yes, Specify: Residual pain from Previous Injuries/Accidents  No  Yes, Specify:

**Later Symptoms**

Head	<input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Light Headedness <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Pain in ear <input type="checkbox"/> Double Vision <input type="checkbox"/> Other Specify:
Neck (with Movement)	<input type="checkbox"/> Pain in Neck <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turn Left <input type="checkbox"/> Popping in Neck <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Turn Right <input type="checkbox"/> Bend Left <input type="checkbox"/> bend Right <input type="checkbox"/> Other Specify:
Shoulders	<input type="checkbox"/> Pain in Shoulder joint <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Muscle Spasms in Shoulder <input type="checkbox"/> Pain across shoulder <input type="checkbox"/> Cant raise arms above [ ] Above shoulder level [ ] Over head <input type="checkbox"/> Other Specify:
Arms and Hands	<input type="checkbox"/> Pain in Fingers <input type="checkbox"/> Numbness in Left Arm <input type="checkbox"/> Hands Cold <input type="checkbox"/> Pin & needles in hands <input type="checkbox"/> Numbness in Right Arm <input type="checkbox"/> Loss of Grip Strength <input type="checkbox"/> Pin & needles in fingers <input type="checkbox"/> Swollen joints in Fingers <input type="checkbox"/> Other Specify:
Chest	<input type="checkbox"/> Chest pain <input type="checkbox"/> Pain Around Ribs <input type="checkbox"/> Shortness of Breadth <input type="checkbox"/> Breast Pain <input type="checkbox"/> Other Specify:
Abdomen	<input type="checkbox"/> Nervous Stomach <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Other Specify:
Mid back	<input type="checkbox"/> Sharp Stabbing <input type="checkbox"/> Mid pain back <input type="checkbox"/> Pain From front to back <input type="checkbox"/> Dull Ache <input type="checkbox"/> Pain in Kidney Area <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Other Specify:
Lower Back	<input type="checkbox"/> Low Back Pain Low back pain is worse when: <input type="checkbox"/> Working <input type="checkbox"/> Lifting <input type="checkbox"/> Stooping <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Lying Down <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Other
Hips, Legs & Feet	<input type="checkbox"/> Pain in Buttocks <input type="checkbox"/> Pain and needles in Legs <input type="checkbox"/> Pain down leg <input type="checkbox"/> Pain in hip joint <input type="checkbox"/> Feet feel Cold <input type="checkbox"/> Swollen Feet <input type="checkbox"/> Numbness in Toes <input type="checkbox"/> Numbness of Leg <input type="checkbox"/> Knee pain <input type="checkbox"/> Leg cramps <input type="checkbox"/> Cramps in Feet <input type="checkbox"/> Other Specify:
General	<input type="checkbox"/> Nervousness <input type="checkbox"/> Fatigue <input type="checkbox"/> Irritable <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Generally Feel Rundown <input type="checkbox"/> Prostate Pain/Swelling <input type="checkbox"/> Depression <input type="checkbox"/> Night Urination <input type="checkbox"/> Cramping <input type="checkbox"/> Irregularity Loss of Sleep: _____hrs/ night Loss of weight: _____lbs Gain weight: _____lbs

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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