BELANGER CHIROPRACTIC LIFE CENTER

Specializing in Atlas Orthogonal Chiropractic Sheila E. Belanger, D.C.
1451B Klondike Road Conyers, GA 30094
Phone 770-760-1394 Fax 770-760-8414

AUTOMOBILE ACCIDENT HISTORY FORM

(PLEASE PRINT)

Patient Name _____ Today's Date _____

Date of Accident _____ Time of Accident _____ AM / PM ☐Daylight ☐Dawn ☐Dusk ☐Dark

City of Accident _____ State of Accident _____ Street Address _____

Was accident on the job? ☐ Yes ☐ No

Road conditions at the time of the accident: □ **WET** □ **DRY** □ **ICY** □ **OTHER**: _____
Did the police come to the accident scene? □ **NO** □ **YES** Is there a report? □ **NO** □ **YES**
Did you go to the hospital? □ **NO** □ **YES,** If ***yes***, which hospital? _____

How did you get to the hospital? _____ What areas of you were X-rayed? _____

What did the hospital do for your injuries? (Collar, splints, medication, etc.) _____

How long did you stay at the hospital? _____ What was their diagnosis? _____

What did they recommended for follow-up care? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? ☐ Driver ☐ Passenger ☐ Rear-seat ☐ Other
Were you aware of the approaching collision prior to impact, or did it catch you by surprise? □ **AWARE** □ **SURPRISE**
Did you lose consciousness (black out) upon impact? □ **NO** □ **YES,** How long? _____
Did you experience a flash of light or explosion in your head? □ **NO** □ **YES**

At the time of the accident, did you become or experience any of the following?

□ Confused	□ Disoriented	□ Light headed	□ Dizzy	□ Nauseated
□ Blurred vision	□ Ringing / buzzing in ears		□ Loss of balance	□ Other

Do you still have any of those symptoms? If yes, which ones?

Check symptoms you have noticed since the accident.

□ Headache	□ Dizziness	□ Depression	□ Fatigue
□ Light bothers eyes	□ Buzzing in ears	□ Diarrhea	□ Neck pain
□ Loss of memory	□ Feet cold	□ Neck stiff	□ Pins and needles in arms
□ Hands cold	□ Fainting	□ Sleeping problems	□ Loss of balance
□ Face flushed	□ Pins and needles in legs	□ Constipation	□ Tension
□ Numbness in fingers	□ Loss of smell	□ Fever	□ Irritability
□ Loss of taste	□ Chest pain	□ Cold sweats	□ Shortness of breath
□ Reduced tolerance to alcohol	□ Stomach upset	□ Ears ring	□ Head seems too heavy
□ Nervousness	□ Numbness in toes	□ Back pain	□ Reduced tolerance to heat

Was any other doctor consulted after your accident? □ **NO** □ **YES**, If ***yes***, who? _____

What was the diagnosis? _____ What was the treatment? _____

How often did you see the doctor? _____ For how long? _____

Have you ever had any complaints in the involved area before? □ **NO** □ **YES**; If ***yes***, what complaints: _____

_____

Have you been involved in any previous accidents? If so, when? _____
Are your work activities restricted as a result of this accident? □ **NO** □ **YES**

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Since the injury are your symptoms: ☐ Improving? ☐ Getting worse? ☐ Same?

Head-rest / restraint: ☐ None ☐ Integrated type ☐ Adjustable type ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the accident? □ **NO** □ **YES**
Was the seat adjustment altered by the accident? □ **NO** □ **YES** Was the seat broken by the accident? □ **NO** □ **YES**
Did air-bag deploy? □ **NO** □ **YES,** If ***yes***, did it strike you? □ **NO** □ **YES**
Were you wearing a seatbelt? □ **NO** □ **YES** □ **Don't Know** If ***yes***, was it a: □ **lap belt** or a □ **shoulder-lap belt ?**
Did you receive any injury or bruise from the seat belt? □ **NO** □ **YES**

Check the following that were damaged during the accident: ☐ Steering wheel ☐ Windshield ☐ Seat ☐ Rear-view mirror
☐ Other:_____

Was your body facing straight forward at the time of the collision? □ **YES** □ **NO,** How was it turned? _____

Was your head pointed forward? □ **YES** □ **NO,** What direction was it turned and by how much? _____

Where were your hands? ☐ One on the wheel ☐ Two on the wheel ☐ Not applicable
Were you wearing a hat or glasses at the time of impact? □ **NO** □ **YES** Were they still on after the accident? □ **NO** □ **YES**

YOUR CAR:
List the year, make and model of the car you were in: YEAR:_____ MAKE:_____ MODEL:_____
Was your car stopped at the time of impact? □ **NO** □ **YES;** If ***yes***, was the driver's foot on the brake? □ **NO** □ **YES**

If ***no***, then estimate the speed of the vehicle you were in: _____ MPH
If your vehicle was moving at the time of impact, was it: □ Slowing down □ Gaining speed □ Steady speed
What is the estimated cost of damage to the vehicle you were in? **$**

THE OTHER CAR:
What is the year, make and model of the other vehicle? YEAR:_____ MAKE:_____ MODEL:_____

Was the other vehicle moving at the time of collision? □ **NO** □ **YES;** If ***yes***, what was the approximate speed? _____MPH
At the time of impact, was the other vehicle: □ Slowing down □ Gaining speed □ Steady speed
Estimate the damage to the other vehicle: □ None □ Minimal □ Moderate □ Major

You may draw the accident here

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in:_____ Name of their auto insurance:_____

Owner of the automobile you were in:_____ Name of their auto insurance:_____

Insurance company phone#:_____ Claim#: _____

Driver of the other automobile:_____ Name of their auto insurance:_____

Owner of the other automobile:_____ Name of their auto insurance:_____

Insurance company phone#:_____ Claim#: _____

Note: A lien may be filed on personal injury accounts.

Have you retained an attorney? □ NO □ YES, Name and Phone #: _____

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PATIENT HISTORY FORM

(PLEASE PRINT)

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name: **Date:**

How did you hear about us? / Who were you referred by? _____

Purpose for contacting us? _____

Other doctors seen for this condition: □ YES □ NO If yes, doctors' names and prior treatments: _____

_____

Other health problems? _____

Check any of the following ailments / conditions that pertain to you.

□ Abdominal cramps	□ Allergies: _____	□ Ankle swelling	□ Arthritis	
□ Bladder trouble	□ Blood clots	□ Breathing difficulty	□ Bursitis	□ Cancer: _____
□ Chest pain	□ Clicking jaw	□ Colitis	□ Constipation	□ Convulsions
□ Depression	□ Diabetes	□ Diarrhea	□ Diverticulitis	□ Dizziness
□ Earaches	□ Eating disorder	□ Excessive thirst	□ Fainting	□ Fatigue
□ Forgetfulness	□ Frequent nausea	□ Gallbladder problems	□ Gas / bloating	□ Headaches / Migraines
□ Hearing difficulty	□ Heartburn	□ Heart condition: _____		□ Hemorrhoids
□ High blood pressure	□ High cholesterol	□ Irregular heartbeat	□ Irritable bowel syndrome	□ Jaw pain / TMJ
□ Liver problems	□ Lung problems / congestion		□ Lupus	□ Lymphedema
□ Numbness / tingling in extremities		□ Pain between shoulders	□ Paralysis: _____	
□ PMS	□ Poor / Excessive appetite		□ Prostate problems	□ Sinus problems
□ Sleep disorder: _____		□ Spasms / cramps	□ Stress	□ Stroke
□ Swelling: _____		□ Tendonitis	□ Varicose veins	□ Vision problems
□ Vomiting	□ Weight trouble			

□ Other: _____

□ Other: _____

Family History: _____

Previous Chiropractic care: □ NO □ YES, Chiropractor name: _____

Date of last visit: _____/_____/_____ Reason: _____

Main complaint	**How intense? (0 – least; 10 – worst)**	**How frequent?**	Is it **Getting Worse, Better, Staying Same?**
1. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	**W B SS**
2. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	**W B SS**
3. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	**W B SS**
4. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	**W B SS**

When did you first notice this/these problem(s)? _____

How does this condition interfere with normal living or working? _____

Was your condition caused by: ☐ Auto ☐ On job injury, Employer: _____ ☐ Other _____

Describe: _____

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List any previous accidents, injuries (ex: car accidents, sports injuries) or surgeries:_____

List any major illnesses or broken bones:_____

Are you currently under any doctor's care? (Who and why):_____

Are you currently taking any medications? □ NO □ YES, For what?_____

♀ Is there any possibility that you might be pregnant? □ NO □ YES, How many weeks?_____

Please enter the date of the first day of your last menstrual period. (Month and Day) _____

Have you tested positive for HIV / AIDS? □ NO □ YES For Hepatitis? □ NO □ YES, Hepatitis: □ **A** □ **B** □ **C** □ **D** □ **E**

Do you use any of the following? If so, how much and how often?

□ Aspirin_____

□ Tylenol_____

□ Ibuprofen_____

□ Antacids_____

□ Antihistamine_____

□ Cigarettes_____ Pk/day_____Years _____

□ Coffee_____

□ Alcohol □ Never □ Social □ Light □ Moderate □ Heavy

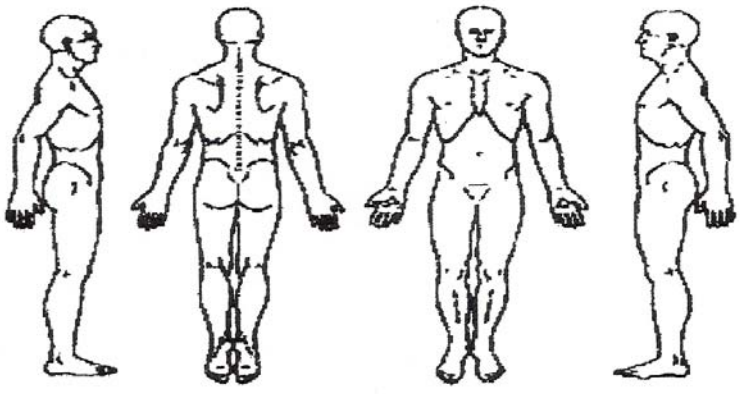
□ Other_____

Health Habits
□ Exercise Regularly
□ Take Nutritional Supplements
□ Consume Dairy Products
□ Drink Soda
□ Drink Alcohol
□ Recreational Drugs

Sleeping Habits
□ Stomach Sleeper
□ Back Sleeper
□ Side Sleeper

Surgical History
Have you had any of the following?
□ Tonsillectomy
□ Appendectomy
□ Hysterectomy
□ Breast Surgery
□ Bunionectomy
□ _____
□ _____
□ _____

Please use the diagram to mark the areas of your body which are causing you pain:



Additional Information:

Thank you for choosing ***Belanger Chiropractic Life Center!***

All information will be strictly confidential.