Cascade Chiropractic Clinic, P.C.
Dr. Mark Kline
6151 - 28th Street, SE
Grand Rapids, MI 49546

Auto Accident

Auto Accident

Name:________________________________ **Today's Date:**__________________ **Date of Acc:**_______________

Your Vehicle Type
Car__ Station Wagon__
Van__ Pickup Truck__
Large Truck__ Bus__
Other________________

Your Position In Vehicle
Driver__ Front Passenger__
Left Rear Passenger__
Right Rear Passenger__
Other__________________

What was your vehicle doing at time of accident?
Stopped: at intersection__ in traffic__ at light__
Making: right turn__ left turn__ Parking__
Proceeding along__ Slowing__ Accelerating__
Other____________________________________

Time/Speed/Damage
Time of Accident_______
Your Speed______mph
Their Speed______mph
Damage to your vehicle
Mild__ Moderate__ Totaled__

Details of Accident
Visibility at Time of Accident
Poor__ Fair__ Good__
Who Hit Who/What
You hit other vehicle__
Other vehicle hit you__

Road Conditions at Time of Accident
Icy__ Wet__ Sandy__ Dark__ Clean & Dry__
Point of Impact
Head-on__ Left Front__ Right Front__
Rear-end__ Left Rear__ Right Rear__

You Hit What(object)___________________________________

Body Position, etc.
Did you see the accident coming? Y__ N__
Were you braced for the impact? Y__ N__
Did you have a seat belt on? Y__ N__
Did you have a shoulder strap on? Y__ N__
Did driver air bag deploy? Y__ N__

Does your vehicle have headrests? Y__ N__
If Yes, What was the position of the headrest at the time of the accident?
Even with top of head__ Even with bottom of head__ Middle of neck__
What was the direction of your head at the time of the impact?
Facing straight forward__ Turned to the right__ Turned to the left__
Did passenger air bag deploy? Y__ N__ Side air bags deploy? Y__ N__

During and After Accident Details
Did your body strike the inside of your vehicle? Y__ N__
If Yes, describe_________________________________
Did you lose consciousness during the injury? Y__ N__
If Yes, for how long?_____________________________
Your vehicle's Estimated Damage:__________________
Damage to their vehicle
Mild__ Moderate__ Totaled__
Did Police show up at scene? Y__ N__
Was an Accident Report Filled Out? Y__ N__

After Accident Symptoms
(check for symptoms right after and in the next few days after accident)
__Headache __Dizziness __Mid back pain __Cold hands
__Neck pain __Nausea __Low back pain __Cold feet
__Neck Stiff __Confusion __Nervousness __Diarrhea
__Fainting __Fatigue __Loss of taste __Depression
__Ringing in ears __Tension __Toe numbness __Anxious
__Loss of smell __Irritability __Constipation __Chest pain
__Pain behind eyes __Shortness of breath __ Sleeplessness
__Other____

Emergency Room After Accident?
Where did you go after the accident?
Home__ Work__ ER(Hosp)__ Other Doctor__
How did you get there?
Drove self__ Someone else__ Ambulance__ Police__
X-rays done? Y__ N__ Was lab work done? Y__ N__
Body parts x-rayed:_______________________________
X-rays revealed:__________________________________
Cervical Collar: Y__ N__ Ice applied: Y__ N__
Instructions:____________________________________

Treatment History for Symptoms after Accident
Dr. ____________________ First Visit Date: ______________
Specialty: ______________________ X-rays: Y__ N__
Types of Treatments: _________________________________
How many treatments rec'd? _______ Still treating? Y__ N__
Did treatments help? Y__ N__ Last visit date: ____________
Dr. ____________________ First Visit Date: ______________
Specialty: ______________________ X-rays: Y__ N__
Types of Treatments: _________________________________
How many treatments rec'd? _______ Still treating? Y__ N__
Did treatments help? Y__ N__ Last visit date: ____________

(REV. 05-07-2009)

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Patient Information

Patient Information

NAME:____ DATE:____________________

NICKNAME (HOW WOULD YOU LIKE US TO REFER TO YOU?) _____________________________

DATE OF BIRTH:___________________ YOUR SS#:______________________________

HOME ADDRESS:____

CITY:_____________________________ STATE:______ ZIP CODE:_______________

HOME PHONE:________________________ WORK PHONE:________________________

CELL PH:________________________ WOULD PREFER: HOME___ WORK___ CELL___

E-MAIL ADDRESS: ____

WHERE ARE YOU EMPLOYED?____

MARRIED___ SINGLE___ WIDOWED___ DIVORCED___ SEPARATED___

SPOUSE'S NAME____

SPOUSE'S EMPLOYER____

HOW WERE YOU REFERRED TO THIS OFFICE?__________________________________

RESPONSIBLE FOR CHARGES AT THIS OFFICE: SELF_____SPOUSE_____

PARENT___________________________ OTHER ___________________________

IS HEALTH INSURANCE INVOLVED? YES____NO____UNSURE____

HEALTH INSURANCE COMPANY____

MEMBER ID# ____________________GROUP# __________INSURED________________

RELATIONSHIP TO INSURED: SELF____SPOUSE____CHILD____OTHER___

INSURED'S SS#_____________________INSURED'S BIRTH DATE___________

OTHER INSURANCE: YES____NO____

IS YOUR CONDITION RELATED TO AN AUTOMOBILE ACCIDENT? YES____NO___

IS YOUR CONDITION A WORK RELATED INJURY? YES____NO____

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS, AND TREATMENTS ARE RENDERED, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF CASCADE CHIRORACTIC CLINIC, P.C.. I AUTHORIZE TREATMENT BY DR. MARK KLINE AND AGREE TO THE RELEASE OF INFORMATION NECESSARY FOR MY TREATMENT OR FOR THE PROCESSING OF INSURANCE CLAIMS.

PATIENT'S SIGNATURE: ____ DATE:_____________

(PARENT OR GUARDIAN IF A MINOR)

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Health Information

Health Information

1) NAME:______________________________ 2) DATE:__________________

3) MAJOR COMPLAINTS:____

____

____

____

____

4) HOW DID THIS CONDITION DEVELOP? ______________________________

____

5) WHEN DID THIS START?____

6) HAVE YOU EVER HAD THIS BEFORE? Y __ N __ WHEN? ____________________

7) THIS HAS BEEN GETTING: BETTER _____% WORSE _____% SAME _____

8) HAVE YOU BEEN SEEN OR TREATED FOR THIS? Y __ N __ HERE? Y __ N __

WHERE? ____

9) WHAT HAVE YOU DONE TO TRY TO RELIEVE THE SYMPTOMS? _______________

____

10) WHAT MAKES THE SYMPTOM(S) WORSE? ____________________________

____

11) WHAT NORMAL ACTIVITIES HAVE YOU CHANGED SINCE THIS STARTED? __________

____

12) HAVE YOU HAD ANY ACCIDENTS OR INJURIES (AUTO OR OTHER)? Y __ N __

IF YES DESCRIBE: ____

____

____

13) LIST ANY MEDICATIONS YOU ARE TAKING: _________________________

____

____

14) SURGERIES (WHEN): ____

____

____

15) HAVE YOU EVER RECEIVED CHIROPRACTIC CARE BEFORE? Y __ N __ WHEN? __________

16) COMMENTS: ____

DOCTOR ____

DATE OF VISIT ___/___/20___ Patient____ Age________________

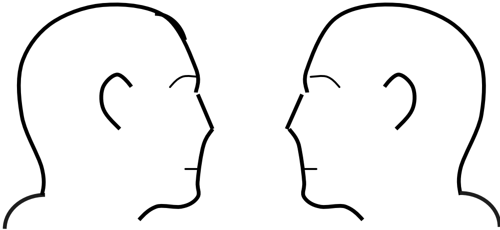
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms ____________________

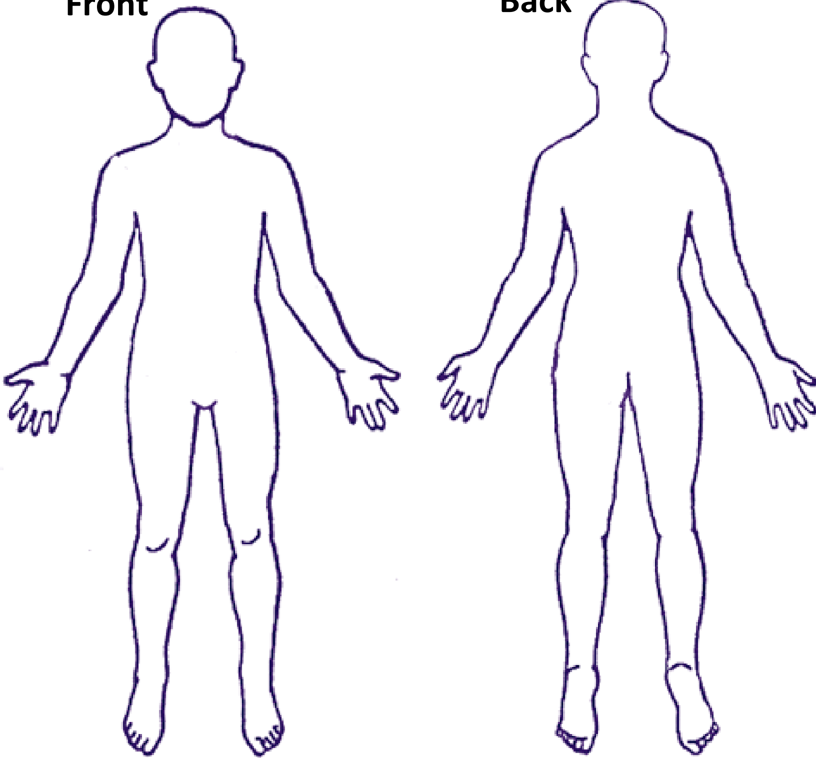
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? ______________________________

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A = Ache
B = Burning
ST = Stabbing
SP = Spasm
N = Numbness
P = Pins and Needles
T = Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE			EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**