

CAD INJURY HISTORY FORM

GENERAL INFORMATION:

Patient's name: _____
Driver's License: _____
SSN: _____
Today's date: _____
Date of injury: _____
Marital status: M S W D

Habits:

None: ____
Smoke: ____ Pk/day ____ Years
Alcohol:
____ Never ____ Social
____ Light ____ Moderate
____ Heavy

At time of crash:

____ Employed
Employer _____
____ Unemployed

Currently:

____ Employed
Employer _____
____ Unemployed

Due to crash: Yes__ No__

Type of work:

__ Office/clerical:
__ light labor
__ moderate labor
__ heavy labor

PAST MEDICAL HISTORY:

Surgeries (dates and residuals):

Fractures (dates and residuals):

Serious illness (dates and residuals):

Workers' comp. Injuries:

(date, Tx, awards, residuals):

PAST MEDICAL HISTORY (Con't)

Sports or other injuries to head, neck or back:

Any prior Hx of current complaints

- 1. _____
- 2. _____
- 3. _____

Prior Tx by DC for these:

- 1. _____
- 2. _____
- 3. _____

CURRENT MEDICAL HISTORY:

Current health problems: ___None

Current medications taken: ___None

INJURY HISTORY GENERAL:

Was the crash on the job?

___ Yes ___ No

You were:

- ___ Driver
- ___ Front seat passenger
- ___ Rear seat passenger
- ___ Motorcycle operator
- ___ Motorcycle passenger
- ___ Other _____

Vehicle driven by:

Your vehicle:

Year _____
Make _____ Model _____

Your estimated speed at moment of crash: _____

- ___ Stopped
- ___ Slowing
- ___ Accelerating

Other vehicle:

Year _____
Make _____ Model _____

Time of day:

- ___ Daylight
- ___ Dawn
- ___ Dusk
- ___ Dark

Road conditions:

- ___ Dry
- ___ Damp
- ___ Wet
- ___ Other _____
- ___ Snow
- ___ Ice

INJURY HISTORY GEN. (Cont'd)

- Head restraints:
- None
- Integral type
- Adjustable type
- Up
- Down
- Don't know

If adjustable, was the position 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 the airbag deploy?

Yes__ No__

If Yes, where you struck?

Yes__ No__

Body position:

- Good
- Forward
- Lean
- Other_____

Head position:

- Forward
- Left
- Right
- Up

Down

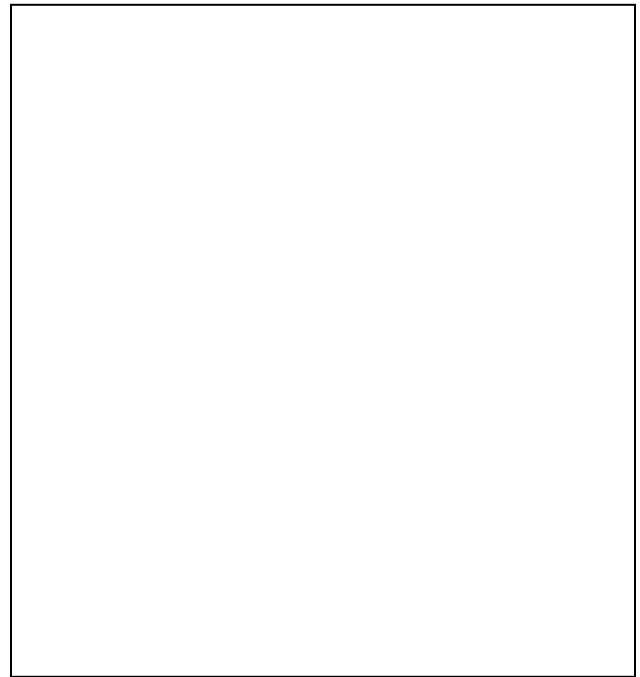
Hands:

- One Hand On wheel
- Two Hands On wheel
- N/A

Brakes applied? Yes__ No__

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? Yes___ No___

If Yes, describe_____

Wearing hat or glasses?

Yes ___ No ___

If Yes, still on after crash?

Yes ___ No ___

Did you lose consciousness?

Yes ___ No ___

If Yes, for how long?_____

Estimated property damage to your vehicle: \$_____

Estimated damage to other vehicle(s):

___ None ___ Moderate

___ Minimal ___ Major

Where police on the scene?

Yes___ No ___

If Yes, was a report made?

Yes___ No ___

AFTER THE CRASH:

Symptoms:

___Headache

___Dizziness

___Nausea

___Confusion/disorientation

___Neck pain

___Paresthesia(s)

If Yes, where?

Extremity pain: Yes___No___

If Yes, Where?

Back pain: Yes___ No___

If Yes, Where?

When did SX first appear?

___Immediately

___Afterward ___ (hrs)

Describe which SX(s):_____

Where did you go after the crash?

___Home

___Work

___Hospital

Mode of transportation?

Pvt. Doctor:_____

EMERGENCY DEPARTMENT:

Radiographs: Yes___ No___

If Yes, describe:

Body parts imaged: _____

Results _____

Special tests: _____

Lab work: Yes___ No___

Referred to: _____

Cervical collar Ice? Yes ___ No ___

Did TX help?: Yes___ No___

Medications: _____

Follow up instructions:

Other: _____

Follow up instructions:

2.

Dr: _____

Specialty: _____

TREATMENT HISTORY:

Date first seen: _____

1. Dr: _____

Referred by:

Specialty: _____

Date first seen: _____

TX type: _____

Referred by:

TX frequency: _____

TX duration: _____

TX type: _____

Currently treating? Yes___ No___

TX frequency: _____

Any disability? Yes___ No___

TX duration: _____

If Yes, describe:

Currently treating? Yes___ No___

Any disability? Yes___ No___

TX HISTORY (Cont'd)

Special tests: _____

Referred to: _____

3. 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 TX help?: Yes__ No__
Follow up instructions:

4. 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 TX help?: Yes__ No__
Follow up instructions:

ORIGINAL CHIEF COMPLAINTS:

1. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): 1, 2, 3, 4

Temporal: _____

Radiation: _____

Severity (1-4): 1, 2, 3, 4

Temporal: _____

4. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): 1, 2, 3, 4

Temporal: _____

2. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): 1, 2, 3, 4

Temporal: _____

3. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____