AUTOMOBILE INJURY HISTORY

Name ____ Date of accident ___________________Time ___________________ _

Where did accident happen? ____

Describe accident in your own words ____

What was your position in car? 0 Driver 0 Passenger. If passenger, were you sitting in 0 Front 0 Right rear 0 Left rear. Did your vehicle strike other vehicle? 0 Yes 0 No Was your car struck by other vehicle? 0 Yes 0 No

Was the impact from 0 The front? 0 From the right side? 0 From the left side? 0 From the rear?

At the time of impact were you 0 Looking straight ahead? 0 Looking right? 0 Looking left?

Were both hands on the steering wheel? 0 Yes 0 No Was your foot on the brake 0 Yes 0 No Were you braced for impact? 0 Yes 0 No

Where in the car were you after the accident? ____ _

Were you wearing seat belts? 0 Yes 0 No Did you strike anything in vehicle at time of impact? 0 Yes 0 No If Yes specify: 0 Steering wheel 0 Dashboard 0 Windshield 0 Side door 0 Arm rest 0 Side window Please state part of body: 0 Chest 0 Chin 0 Knee 0 Shoulder 0 Hand 0 Head

Immediately following the accident, how did you feel? ____ _

Were you unconscious? 0 Yes 0 No In a daze 0 Yes 0 No Did you go to the hospital 0 Yes 0 No If you went to the hospital, when? At time of accident 0 Yes 0 No Next day 0 Yes 0 No

How did you get to hospital? Ambulance 0 Yes 0 No Private transportation 0 Yes 0 No

Did the ambulance attendants place you in neck collar? 0 Yes 0 No Splints? 0 Yes 0 No Brace? 0 Yes 0 No

Name of hospital ____

Attended by Dr. ____ Were you X-Rayed at hospital 0 Yes 0 No

If so, what was the diagnosis? ____

Were you admitted to the hospital? 0 Yes 0 No How long did you stay? ____

What treatment was rendered? ____

Describe symptoms from the day following accident to today's date ____

What recommendations were made? See own doctor? 0 Yes 0 No See orthopedic doctor? 0 Yes 0 No Physical therapy 0 Yes 0 No

Before the injury were you capable of working on an equal basis with others your age? 0 Yes 0 No Are your work activities restricted as a result of this accident? 0 Yes 0 No

If yes, give percentage of restriction: ___________ .

Are your home activities restricted as a result of this accident? 0 Yes 0 No

Do you have a copy of police report? 0 Yes 0 No If Yes, please bring a copy to our office.

Signature ____---'~ __ Date ____________________________________ _

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NOTICE OF PRIVACY POLICY

Your health record in our office will remain confidential. A copy of our office privacy policy is posted in the waiting room. A printed copy is available upon request.

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by Sharon R. Martinez, D.C. and/or other licensed doctors of chiropractic who now or in the future may treat me while employed by Dr. Martinez. I understand that there are some risks to chiropractic treatment, as there are in the practice of medicine. I wish to rely on the doctor to exercise judgment during the course of treatment and to perform those procedures which the doctor feels, at the time and based upon the facts then known, are in my best interests.

Dr. Martinez will take my health history before performing chiropractic adjustments. Health history information I provide should be complete and include any necessary as well as elective surgeries I may have undergone.

Risks to treatment include but are not limited to rib fractures, dislocations, and sprains. A rare form of stroke known as VBA (vertebrobasilar artery) stroke has been associated with patients who present with a sudden onset of severe neck pain. The risk of VBA stroke occurring after a chiropractic adjustment is not higher than the risk of suffering VBA stroke after a visit to the medical doctor's office. In other words, patients who may already be in the initial stages of this rare event (estimated at about 83-250 patients in the United States per year) are more likely to seek chiropractic and/or medical attention. *(Source: Cassidy et al., Bone and Joint Decade Task Force on Neck Pain and its Associated Disorders, 2008.)*

In comparison, adverse reactions to non-steroidal anti-inflammatory drugs (Motrin, Tylenol, Advil, etc.) cause 33,000 deaths per year in the United States. Adverse reactions to all prescription drugs cause well over 160,000 adverse incidents per year. *(Sources: Journal of American Medical Association, RAND study.)*

______________________________	______________________________
Print Patient's Name	Date
______________________________	______________________________
Patient's Signature	Parent or Legal Guardian's Signature (if applicable)