

StoneRidge Chiropractic

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MOTOR VEHICLE ACCIDENT

Date of Injury: _____ Today's Date: _____

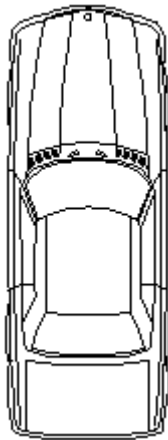
Name: _____ Birth Date: _____ Age: _____ Male Female

Describe how the injury happened: _____

AUTOMOBILE ACCIDENT:

Damage \$ _____

FRONT



Were you the: Driver

Passenger: Front Rear

Seat Belt: Yes No Lap Shoulder

Vehicle was: Moving At a stop

Vehicle Struck: Head-on Rear-ended

Passenger side Driver side

During Impact: Brace w/arms Brace w/legs Steering wheel

Dash Seat Floor Brakes Don't remember

Head: Straight Turned: Right Left Strike headrest

REAR

O = Where patient sat

X = Where impact occurred

Strike any part of body: (Against what) _____

After collision: Lost consciousness? _____ Minutes: _____

Did you feel? Nervous Stunned Scared Dizzy Disoriented

Lightheaded Confused

Immediate symptoms: _____

Subsequent symptoms: _____

Evaluated by Paramedics? _____ Taken to Hospital? _____ Via ambulance? _____

Initial treatment: _____

Doctor's Name & Specialty: _____

Type of treatment: _____

Subsequent treatment: (including all Doctors and testing)

1

2

3

Was anyone in the vehicle with you?

CURRENT COMPLAINTS

1

2

3

PAST MEDICAL HISTORY

Prior injuries: Motor Vehicle:

Work:

Sports:

Other:

Major surgeries:

Hospitalizations:

Major illnesses: Hypertension Heart Disease Diabetes Ulcers Cancer

Lung Conditions Kidney Problems Hernia Tuberculosis

Other:

Family history of any of the above conditions? (Who/Which)

Is there any chance that you are pregnant at this time? Yes No

Allergies:

Current Medications:

Events of Accident in Patients Own Words

Multiple horizontal lines for text entry.