Thalman Chiropractic & Rehab Clinic

606A Eastgate, Carbondale, IL 62901 - info.thalmanchiropractic@gmail.com - Phone: 618-549-8228 - Fax: 618-549-6399

Personal Injury Patient Basic Information

Patient Name: _____

Date of Accident: _____

Insurance Policy Holder *(if different than the patient):* _____

Insurance Policy Company & Number:

_____

CLAIM NUMBER:

_____

ADJUSTOR NAME & DIRECT EXTENTION NUMBER:

_____

***** Please give a copy of the accident report to the front desk when you return this document*****

The accident report is required for accurate assessment and reimbursement purposes.

1. **Description of injury/onset:**
   Enter the full description of accident, injury, or onset.

_____

_____

_____

_____

_____

_____

2. **During and after the accident details:**
   Enter the details of your condition during and after the accident/onset.

_____

_____

_____

_____

_____

3. **Automobile accident description:**

Your vehicle type:
- □ car
- □ van
- □ bus
- □ station wagon
- □ pick-up truck
- □ large truck
- □ other: _____

Your position in the vehicle:
- □ driver
- □ front passenger
- □ left rear passenger
- □ right rear passenger

Your vehicle was:
- □ stopped at a light
- □ stopped in traffic
- □ making a left turn
- □ making a right turn
- □ slowing down
- □ stopped at an intersection
- □ parking
- □ accelerating
- □ other: _____

4. Automobile accident information:

Please provide the information to the best of your ability. If you do not know an answer, do not provide an answer.

Time of accident: _____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph

Damage to your vehicle:
□ mild
□ moderate
□ totaled

Object you hit *(if applicable):* _____

Visibility at time of accident:
□ poor
□ fair
□ good

Who hit who/what:
□ I hit the other vehicle
□ the other vehicle hit me

Point of impact:
□ head-on
□ rear-end
□ left front
□ left rear
□ right front
□ right rear

Road Conditions:
□ icy
□ wet
□ loose gravel
□ dark
□ clean & dry

5. Passenger position information:

My vehicle has headrests: □ Yes □ No

At the time of impact, the position of the *headrest* was:
□ even with top of my head
□ even with the bottom of my head
□ in the middle of my neck
□ I don't remember
□ not applicable

At the time of impact, my *head* was:
□ facing straight forward
□ turned to the right
□ turned to the left
□ I don't remember
□ not applicable

I saw the accident coming:	□ Yes	□ No
I was braced for the impact:	□ Yes	□ No
I was wearing my seatbelt:	□ Yes	□ No
My shoulder harness was on:	□ Yes	□ No
The driver-side airbag deployed:	□ Yes	□ No
The passenger-side airbag deployed:	□ Yes	□ No
The side airbags deployed:	□ Yes	□ No

6. Additional information:

_____

_____

_____

7. During the accident:

My body hit the inside of my vehicle: □ Yes □ No
If yes, describe: _____

I lost consciousness: □ Yes □ No
If yes, for how long? _____

8. <u>After the accident</u> I had/have the following symptoms:
Check all of the boxes that apply to you.

□ headache	□ neck pain	□ tension	□ pain behind eyes
□ dizziness	□ nausea	□ toe numbness	□ shortness of breath
□ mid-back pain	□ low back pain	□ anxiety	□ sleeping problems
□ cold hands	□ cold feet	□ loss of taste	□ chest pain
□ neck stiffness	□ confusion	□ loss of smell	□ ringing in ears
□ nervousness	□ diarrhea	□ irritability	□ depression
□ fainting	□ fatigue	□ constipation	

The police came to the scene: □ Yes □ No

How I left the scene:	**When I left the scene, I went to:**
□ I drove myself	□ my home
□ someone else drove me	□ work
□ in an ambulance	□ my primary care doctor
□ with the police	□ the emergency room

If you went to the ER, name of the facility: _____

Did you have x-rays or lab work done at the ER? □ Yes □ No
If yes, may we contact the facility for a copy of your reports? □ Yes □ No

***If you have the report(s) with you, please give a copy to the front desk when you return this document.*

Body part(s) x-rayed: _____
The x-ray revealed: _____

Other important information related to your ER visit:_____
_____
_____

9. Description of Symptoms:

<u>Symptom 1</u> *(describe your primary symptom):*

_____

_____

<u>Type</u> of pain:

□ dull	□ cutting	□ tingling	□ spasm	□ pounding
□ sharp	□ throbbing	□ burning	□ stinging	□ constricting
□ aching	□ numbing	□ cramping	□ shooting	□ stabbing

Frequency* of pain** *(during the time you are awake)**:

□ sometimes (25%)
□ half of the time (50%)
□ most of the time (75%)
□ all of the time (100%)

***Intensity* of pain:**

□ it does NOT affect my daily activities
□ it limits my ability to perform my daily activities
□ it prevents me from performing daily activities

Radiation* of pain** *(to other parts of your body)**:

	Left	*Right*	*Both*
□ head	□	□	□
□ neck	□	□	□
□ shoulder	□	□	□
□ arm	□	□	□
□ hand	□	□	□
□ hip	□	□	□
□ leg	□	□	□
□ foot	□	□	□

□ not applicable

***Factors* that influence pain:**

	Brings on	*Aggravates*	*Relieves*
□ bending forward	□	□	□
□ bending backward	□	□	□
□ bending left	□	□	□
□ bending right	□	□	□
□ twisting left	□	□	□
□ twisting right	□	□	□
□ coughing	□	□	□
□ sneezing	□	□	□
□ straining	□	□	□
□ standing	□	□	□
□ sitting	□	□	□
□ lifting	□	□	□
□ morning	□	□	□
□ evening	□	□	□
□ laying down	□	□	□

Symptom 2 *(describe your secondary symptom):*

_____

_____

Type of pain:

□ dull	□ cutting	□ tingling	□ spasm	□ pounding
□ sharp	□ throbbing	□ burning	□ stinging	□ constricting
□ aching	□ numbing	□ cramping	□ shooting	□ stabbing

Frequency of pain *(during the time you are awake)**:***

□ sometimes (25%)
□ half of the time (50%)
□ most of the time (75%)
□ all of the time (100%)

Intensity of pain:

□ it does NOT affect my daily activities
□ it limits my ability to perform my daily activities
□ it prevents me from performing daily activities

Radiation of pain *(to other parts of your body)**:***

	Left	*Right*	*Both*
□ head	□	□	□
□ neck	□	□	□
□ shoulder	□	□	□
□ arm	□	□	□
□ hand	□	□	□
□ hip	□	□	□
□ leg	□	□	□
□ foot	□	□	□

□ not applicable

Factors that influence pain:

	Brings on	*Aggravates*	*Relieves*
□ bending forward	□	□	□
□ bending backward	□	□	□
□ bending left	□	□	□
□ bending right	□	□	□
□ twisting left	□	□	□
□ twisting right	□	□	□
□ coughing	□	□	□
□ sneezing	□	□	□
□ straining	□	□	□
□ standing	□	□	□
□ sitting	□	□	□
□ lifting	□	□	□
□ morning	□	□	□
□ evening	□	□	□
□ laying down	□	□	□

10. Activities of Daily Living Assessment

Please check the box next to each activity you currently have difficulty doing as a result of your accident/illness:

Self Care & Personal Hygiene

□ bathing
□ drying hair
□ brushing teeth
□ cleaning dishes
□ going to the toilet
□ putting on shirt
□ putting on pants
□ tying shoes
□ washing face
□ putting on shoes
□ preparing meals
□ taking out trash
□ combing hair
□ showering
□ doing laundry
□ eating
□ washing hair
□ making the bed

Physical Activities

□ walking
□ standing
□ sitting
□ squatting
□ bending forward
□ bending back
□ bending left
□ bending right
□ twisting left
□ kneeling
□ reclining
□ reaching
□ putting on shirt
□ leaning forward
□ leaning back
□ leaning left
□ leaning right
□ twisting right
□ *standing* for long periods of time
□ *sitting* for long periods of time
□ *walking* for long periods of time
□ *kneeling* for long periods of time

Functional Activities

□ carrying small objects
□ carrying large objects
□ carrying a briefcase
□ carrying a purse
□ lifting weights off *floor*
□ lifting weights off *table*
□ pushing things while *standing*
□ pushing things while *seated*
□ pulling things while *standing*
□ pulling things while *seated*
□ exercising *upper* body
□ exercising *lower* body
□ exercising *arms*
□ exercising *legs*
□ climbing *stairs*
□ climbing *incline*

Social & Recreational Activities

□ bowling
□ swimming
□ roller skating
□ dancing
□ hobbies
□ jogging
□ competitive sports
□ golfing
□ dating
□ dining out

Traveling

□ driving a *motor vehicle*
□ driving for *long periods of time*
□ riding as a *passenger in a motor vehicle*
□ riding as a *passenger for long periods of time*

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

_____

_____

_____

_____

_____

_____

11. Treatment for your symptoms PRIOR to your first appointment at Thalman Chiropractic

Did you receive ANY treatment for symptoms that resulted from your accident/illness? □ Yes □ No

If yes, please provide the following information:

***First* visit date:** **_____ / _____ / _____**

Doctor's name: _____

Doctor's specialty: _____

Treatment: _____

# of visits to date: **_____** **Currently receiving treatments?** □ Yes □ No

Did treatments benefit you? □ Yes □ No

***Last* visit date:** **_____ / _____ / _____**

Did you have similar symptoms ***prior to your accident?***

□ I did NOT have symptoms similar to my current complaint(s)
□ my current complaint(s) DID exist *but had not been bothering me*
□ my current complaint(s) DID exist and *were worsened by the accident/injury*

***If applicable* -** My most recent prior symptom occurred: □ months ago
□ years ago
□ on a specific date: **_____ / _____ / _____**

Has your history contributed to your current symptoms?

□ my history HAS contributed to my current symptoms
□ my history HAS NOT contributed to my current symptoms
□ I am NOT SURE if my history has contributed to my current symptoms
□ not applicable

Completed By *(print name)***:** _____

Signature: _____

Date: _____