FULL SPECTRUM
CHIROPRACTIC PLLC

101 Rogers Street NW
Olympia WA 98502
Tel: (360) 269-3448
Fax: (360) 705-0421
info.fullspectrumchiro@gmail.com

AUTO-RELATED INJURY

Section 1: About You

Name: _____ Today's Date: _____ Case#: _____

Section 2: Auto Related Accident

Date & Time of Accident: _____ O AM O PM

Were you the:

O Driver O Front Passenger O Rear Passenger

Number of people in accident vehicle? _____

Did the police come to the accident site? O Yes O No
Was a police report filed? O Yes O No
Were there any witnesses? O Yes O No
Were you wearing your seatbelt? O Yes O No
Was this vehicle equipped with airbags? O Yes O No
If so, did it/they deploy during the accident? O Yes O No

If a traffic violation was issued, to whom was it issued?

_____

What did your vehicle impact? O Another vehicle O Other

If other, explain: _____

In relation to the base of your skull, where was the headrest?

O Above the skull O Below the skull O At base of the skull

Did any part of your body strike anything in the vehicle?

O Yes O No

If yes, explain: _____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

Extent of damage to your vehicle:

O Light cosmetic O Structural
O Totalled O Moderate cosmetic

In which direction were you headed?

O N O S O E O W

What was the approximate speed of your vehicle? _____

Did the impact to your vehicle come from the:

O Front O Left side
O Rear O Other: _____
O Right side

During impact were you facing: O Right O Left O Forward

Were you: O Aware or O Surprised by the impact?

If accident vehicle made impact with another vehicle:

Make/model of other vehicle: _____

Direction other vehicle was headed? O N O S O E O W

Approximate speed of other vehicle? _____

In your words, please describe the accident: _____

_____

_____

FULL SPECTRUM
CHIROPRACTIC PLLC

Name: _____ Case#: _____

Section 3: After Injury

Have you gone to a hospital/seen any other doctor?
O Yes O No

When did you go?
O Just after accident O Next Day O 2 days+

How did you get there?
O Ambulence O Private transportation

Name of hospital and/or attending doctor:_____

_____

Was he/she a:
O D.C. O M.D. O D.O. O D.D.S.

Describe any treatment you received:_____

_____

Indicate the symptoms that are a result of this accident:

- O Dizziness
- O Memory loss
- O Headaches
- O Blurred vision
- O Buzzing in ear
- O Ears Ringing
- O Jaw problems
- O Arms/shoulder pain
- O Numb hands/fingers
- O Chest pain
- O Shortness of breath
- O Stomach Upset
- O Difficulty sleeping
- O Irritability
- O Fatigue
- O Tension
- O Neck pain
- O Neck stiffness
- O Nausea
- O Low back pain
- O Back pain
- O Back stiffness
- O Leg pain
- O Numb feet/toes

O Other: _____

Condition getting worse?
O Yes O No O Constant O Comes & goes

Indicate degree of comfort for the following activities:

	Comfortable	Uncomfortable (even if only sometimes)	Painful
Lying on back	O	O	O
Lying on side	O	O	O
Lying on stomach	O	O	O
Sitting down	O	O	O
Standing up	O	O	O
Stretching	O	O	O
Lovemaking	O	O	O
Walking	O	O	O
Running	O	O	O
Sports	O	O	O
Working	O	O	O
Lifting	O	O	O
Bending	O	O	O
Kneeling	O	O	O
Pulling	O	O	O
Reaching	O	O	O

Were x-rays taken? O Yes O No
Was medication prescribed? O Yes O No
Have you been able to work since the injury? O Yes O No
Are work activities restricted? O Yes O No

Did accident render you unconscious?

If yes, explain: _____

Please describe how you felt immediately after the accident: _____

_____

_____

Section 4: Legal

Have you retained an attorney? O Yes O No

If yes, whom? _____ His/her phone #: _____

FULL SPECTRUM
CHIROPRACTIC PLLC

Name: _____ Case#: _____

Section 5: Recovery

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

- ○ Standing
- ○ Sitting
- ○ Walking
- ○ Lifting
- ○ Driving
- ○ Twisting
- ○ Crawling
- ○ Bending
- ○ Operating equipment
- ○ Work with arms above head
- ○ Typing
- ○ Stooping
- ○ Other _____

What positions can you work in with minimum physical effort and for how long? _____ ○ N/A

Prior to the injury, were you capable of working on an equal basis with others your age? ○ Yes ○ No ○ N/A

Do you work with others who can help you with any heavy lifting? ○ Yes ○ No ○ N/A

While in recovery, is there any light duty work you could request? ○ Yes ○ No ○ N/A

Section 6: Notes