CrossWinds Chiropractic
Dr. David Rheaume, D.C. D.A.B.C.O.
15351 S.E. 82nd Drive
Clackamas, Or. 97015
Phone: (503)342-6644

Patient:_____

DOB:_____

Automobile Accident
Fact Sheet
Today's Date _____

Name:_____

Date of Accident:_____Time of Accident:_____AM or PM

City of Accident:_____Street of Accident:_____

Road conditions at the time of this accident: _____WET ____DRY ____ICY ____OTHER

Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

If so, what bleeding cuts did you get during this accident

_____

What bruises did you get during this accident?_____

_____

On what part of the auto did the following body parts hit:

Head hit_____	Chest hit_____
Right shoulder_____	Left shoulder_____
Right arm_____	Left arm_____
Right hip_____	Left hip_____
Right leg_____	Left leg_____
Right knee_____	Left knee_____

Did the police come to the accident scene?_____ Were you taken to the hospital?_____
If "yes" what is the name and location of the hospital?_____
How did you get to the hospital?_____
What parts of your body were X-rayed at the hospital?_____

Have you been treated by another doctor for this accident _____YES _____NO
I "yes" please provide the doctors name and address_____
What type of treatment did you receive?_____
How long were you treated by this doctor?_____
Are you _____improved ____unchanged ____getting worse

What medications are you taking? _____
Do these medications help? ____yes ____no ____not sure

Have you had physical therapy? ____yes ____no ____if "yes" how often? _____
Does physical therapy help? ____yes ____no ____not sure

_____

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Fact Page 2

MECHANISM OF INJURY:
The following question pertain to you and the vehicle you were in.

Where were you seated in the vehicle during the time of the accident?_____
_____

Were you aware of the approaching collision or did you not see it coming?_____

Did you lose consciousness (black out)? If yes, when?_____
And for how long were you unconscious?_____

Was the head rest of the seat you were in ____Level, ____Above, or ____ Below the top of your head?

Were you wearing a safety belt? ___ No ___Yes, if yes, was it a ____Shoulder-Lap restraint, ____ Lap restraint, or ____ Other? If other, what was it? _____

PRIOR INJURY:
Prior to this accident, did you have similar physical complaints as you have now? ____yes ____no
____not sure If "yes" please describe: _____
_____

Were these similar complaints due to a previous accident? ____yes ____no

What is the year, make, and model of the vehicle you were in?
_____
What is the year, make, and model of the other vehicle involved in the collision?
_____
Did you file a Personal Injury Protection (PIP) claim with your insurance company? _____
If yes, what is your PIP claim Number? _____
Insurance Company _____

PRESENT COMPLAINTS:

Please check you major points of concern:

___ Headache	___ Head seems heavy	___ Light bothers Eyes
___ Neck Pain	___ Pins & Needles in Legs	___ Loss of Memory
___ Stiff Neck	___ Pins & Needles in Arms	___ Ears Ringing
___ Back Pain	___ Numbness in fingers	___ Loss of Balance
___ Pain down rt Leg	___ Dizziness	___ Numbness in Toes
___ Pain down lft Leg	___ Fatigue	___ Loss of Smell
___Sleeping Problems	___ Depression	___ Loss of Taste

Symptoms other then listed above:
_____

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Automobile Accident
Fact Page 3

Please indicate below where your symptoms are located:

KEY

Numbness	########
Pins/Needles	00000000
Pain	XXXXXXXX
Stabbing Pain	//////////