VALENTE
CHIROPRACTIC

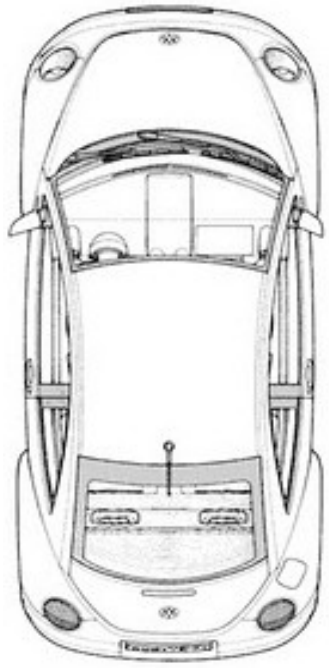
Motor Vehicle Collision Form

Name: _____ **DOB:** _____ **Today's Date:** _____

Report of Accident:

Date of Accident:_____ Time of Accident:_____❑A.M. ❑P.M. City of Accident: _____
Street of Accident that your car was on: _____ Cross Street (intersection): _____
Road conditions at the time of incident: ❑Wet ❑Dry ❑Icy ❑Other _____
Were there any witnesses? ❑Yes ❑No Were you wearing your seat belt? ❑Yes ❑No
Did the police come to the scene of the accident? ❑Yes ❑No Was an accident report filed? ❑Yes ❑No
If a traffic violation was issued, to whom was it issued? _____
Please explain the details of the accident to the best of your knowledge: _____
_____
_____
_____

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



The following questions pertain to you, the patient, and the vehicle you were in:
Number of people in accident vehicle: _____
Were you the: ❑Driver ❑Front Passenger ❑Rear Passenger
Were you ❑aware of the approaching collision ***or*** ❑surprised by impact?
Were you rendered unconscious? ❑Yes ❑No If yes, for how long?_____
In relation to the base of your skull, where was the headrest?
❑Above ❑Below ❑At base of skull
Was this vehicle equipped with airbags? ❑Yes ❑No
If yes, did it/they inflate? ❑Yes ❑No
What did your vehicle impact? ❑Another Vehicle ❑Other _____
_____

Vehicle Information & Velocity pertaining to the vehicle you were in:
Vehicle Year: _____ Make:_____ Model: _____
What direction was your vehicle traveling? ❑North ❑South ❑East ❑West
Was your car ❑Moving ***or*** ❑Stopped
If your car was moving:
How fast were you traveling? Approximately _____ MPH
Just before impact, the vehicle you were in was:
❑Slowing down ❑Speeding Up ❑Constant Speed
Did the impact to your vehicle come from the:
❑Front ❑Rear ❑Right Side ❑Left Side ❑Other: _____

The following questions pertain to the other vehicle involved in the accident:
Other Vehicle Year: _____ Make:_____ Model: _____
What direction was the other vehicle traveling? ❑North ❑South ❑East ❑West
Was the other car ❑Moving ***or*** ❑Stopped
If the other car was moving:
How fast was it traveling? Approximately _____ MPH
Just before impact, the other car was:
❑Slowing down ❑Speeding Up ❑Constant Speed

Were there bleeding cuts caused by the accident? ❑Yes ❑No Where: _____
Where there any bruises caused by the accident? ❑Yes ❑No Where:_____
If any part of your body struck anything during the collision please describe what and where: _____
_____
What were the cost of damages to the vehicle you were in? $_____
Which (if any) of the following car parts broke during the accident:
❑Windshield ❑Steering Wheel ❑Front Seat ❑Back Seat ❑Side Window (R/L) ❑Other_____
Was the trunk of your body pointed straight forward at the time of impact? ❑Yes ❑No
If No, which direction was it pointed, and by how much? _____

Was your head pointed straight forward at the time of impact? ❑Yes ❑No
If No, which direction was it turned, and by how much? _____

If you have been involved in previous auto accidents, please list the year of each incident:

_____

Please list any additional information not covered above that we should know about:

_____

_____

_____

Insurance Information:

Name of Insurance Company:_____Telephone #: _____
Address:_____City: _____ State: _____ Zip: _____
Insured's Name: _____ Insured's SS #: _____ DOB: _____
Insured's Employer: _____ Policy #: _____ Claim #: _____
Name of Claim Representative: _____ Telephone #: _____

Attorney Information:

Name of Attorney/Law Office: _____ Telephone #: _____
Address of Attorney:_____ City: _____ State: _____ Zip:_____

Medical Care:

Have you gone to a Hospital or seen any other Doctor? ❑Yes ❑No
When did you go? ❑Just after accident ❑Next Day Other:_____
Mode of Transportation: ❑Ambulance ❑Privately transported
Name of Hospital and/or Attending Doctor:_____
_____
Was he/she a: ❑D.C. ❑M.D. ❑D.O. ❑D.D.S. ❑P.A.

Were X-Rays taken? ❑Yes ❑No
If yes, what was X-Rayed: _____
_____
Was medication prescribed? ❑Yes ❑No
Describe any treatment you received:
_____

Work:

To evaluate the effect that continuing work will have on your recovery please complete the following:
Have you been able to work since the injury? ❑Yes ❑No

Are your work activities restricted as a result of your injuries sustained? ❑Yes ❑No

How many hours are in your normal work day? _____

What can you do for work 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

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

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:
❑Standing ❑Sitting
❑Walking ❑Lifting
❑Driving ❑Twisting
❑Crawling ❑Bending
❑Operating equipment ❑Working with arms above head
❑Typing ❑Stooping
❑Other: _____

Complaint(s)/Pain Location(s):

❑Dizziness
❑Memory Loss
❑Blurred vision
❑Ringing/Buzzing in ear
❑Left ❑Right ❑Bi-lat
❑Difficulty sleeping
❑Fatigue
❑Irritability
❑Stomach Upset
❑Nausea
❑Migraine(s)
❑Headache(s)

❑Neck
❑pain ❑stiffness
❑Jaw problems
❑Arm pain
❑Left ❑Right ❑Bi-lat
❑Shoulder pain
❑Left ❑Right ❑Bi-lat
❑Numb Hands/Fingers
❑Left ❑Right ❑Bi-lat
❑Chest pain
❑Shortness of breath
❑Tension

❑Upper back
❑pain ❑stiffness
❑Mid back
❑pain ❑stiffness
❑Lower pain
❑pain ❑stiffness
❑Leg pain
❑Left ❑Right ❑Bi-lat
❑Numb Feet/Toes
❑Left ❑Right ❑Bi-lat
❑Other: _____

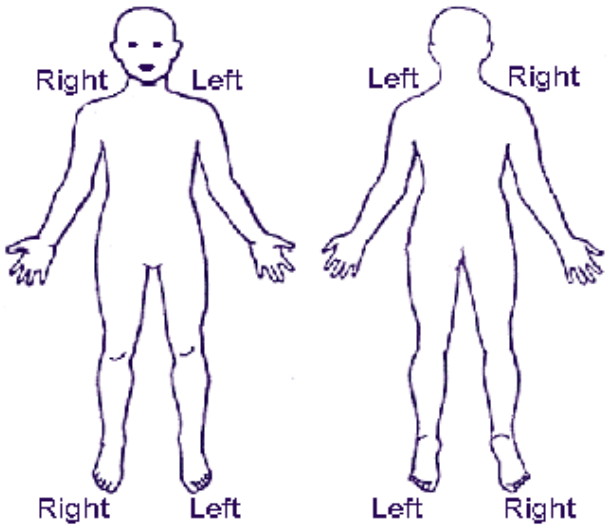
Pain Intensity Prior to the Accident

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Front *Back*



On the image please indicate where you are experiencing your symptoms.

Since the Date of Injury on: _____

How would you describe the character of your condition/pain?
(please check all that apply)

❑Sharp ❑Dull ❑Tingling ❑Numb
❑Aching ❑Shooting ❑Radiating ❑Burning
❑Throbbing ❑Cramping ❑Stiffness ❑Swelling
❑Other _____

Is your condition getting worse?
❑Yes ❑No ❑Constant ❑Comes & Goes

How often do you experience your symptoms?
❑ Constantly (76%-100% of the time)
❑ Frequently (51%-75% of the time)
❑ Occasionally (26%-50% of the time)
❑ Intermittently (0%-25% of the time)

When do you experience your symptoms?
Ex: every day, most days, some days, a few times a year
_____

	Comfortable	Uncomfortable	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Lovemaking	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Bending	❑	❑	❑
Lifting	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑
Standing from a seated position	❑	❑	❑
Other: _____	❑	❑	❑

What have you tried to help alleviate your condition?

_____
_____
_____
_____
_____

Does your condition interfere with your....
❑Sleep
❑Work
❑Daily Routine
❑Recreational activities
❑Other: _____

Additional information / Any recent falls and/or injuries / Prior condition related medical history:

_____
_____
_____
_____
_____
_____

Patient Signature _____ **Today's Date:**_____