Mankato Chiropractic & Mankato's Healing Touch

31 Navaho Ave., Mankato, MN 56001
507-345-4035

1 **ABOUT YOU**
Today's Date: _____
Name: _____

2b **AUTO RELATED ACCIDENT**
Date of Accident: _____
Time of Accident: _____
Were you the ___ Driver ___ Front Passenger
___ Rear Passenger
If a traffic violation was issued, to whom was it issued?
_____
Number of people in accident vehicle? _____
Did the police come to the accident site? ___ Y ___ N
Was a police report filed? ___ Y ___ N
Were there any witnesses? ___ Y ___ N
Were you wearing your seat belt? ___ Y ___ N
Was this vehicle equipped with airbags? ___ Y ___ N
If yes, did it/they inflate? ___ Y ___ N
In relation to the base of your skull, where was the headrest? ___ Above ___ Below ___ At base of skull
What did your vehicle impact? ___ Another vehicle
___ Other _____
Did any part of your body strike anything in the vehicle? ___ Y ___ N
If yes, please describe: _____
_____
_____
Make & model of the vehicle you were occupying?
_____
Name of street on which you were traveling?
_____
In which direction were you headed? ___ N ___ S
___ E ___ W
City & State of accident: _____
Did the impact to your vehicle come from the:
___ Front ___ Rear ___ Right Side
___ Left Side ___ Other _____
During impact, were you facing: ___ Right ___ Left
___ Forward ___ Other _____
Were you ___ aware or ___ surprised by the impact?
If accident vehicle made impact with another vehicle...
Make and model of that other vehicle? _____
_____
Direction other vehicle was headed? ___ N ___ S
___ E ___ W
In your own words, please describe the accident: ___
_____
_____
_____
_____
_____

3 **AFTER INJURY**
Did accident render you unconscious? ___ Y ___ N
If yes, for how long? _____
Please describe how you felt immediately after the accident: _____
_____
_____
Have you gone to a Hospital or seen any other Doctor for this condition? ___ Y ___ N
When did you go? ___ Just after accident
___ The next day ___ 2 days plus
How did you get there? ___ Ambulance or
___ Private transportation
Name of Hospital and/or Attending doctor: _____
_____
Was he/she a ___ D.C. ___ M.D. ___ D.O. ___ D.D.S.
Describe any treatment you received: _____
_____
Were x-rays taken? ___ Y ___ N
Please list any medications you were prescribed:
_____
Have you been able to work since this injury?
___ Y ___ N
Are your work activities restricted as a result of this injury? ___ Y ___ N
___ Unable to work

Please indicate the symptoms that are a result of this accident:

___ Dizziness	___ Difficulty sleeping
___ Jaw problems	___ Nausea
___ Memory loss	___ Irritability
___ Arms/Shoulder pain	___ Back pain
___ Headache(s)	___ Fatigue
___ Numb Hands/Fingers	___ Lower back pain
___ Blurred vision	___ Tension
___ Chest Pain	___ Back stiffness
___ Buzzing in ear	___ Neck pain
___ Shortness of breath	___ Leg pain
___ Ears ringing	___ Neck stiff
___ Stomach upset	___ Numb Feet/Toes
___ Other _____	

Is your condition getting worse? ___Y ___ N
___ Constant ___ Comes & goes
Indicate your degree of comfort while performing the following activities:
1=Comfortable 2=Uncomfortable 3=Painful (even if only sometimes)

___ Lying on back	___ Lying on side
___ Lying on stomach	___ Sitting
___ Standing	___ Stretching
___ Lovemaking	___ Walking
___ Running	___ Sports
___ Working	___ Lifting
___ Bending	___ Kneeling
___ Pulling	___ Reaching

Have you retained an attorney ___ Y ___ N
If yes, whom: _____
His/Her Phone #: _____

4 **RECOVERY**
To evaluate the effect that continuing work will have on your recovery, please complete the following:
How many hours are in your normal work day? _____
Please indicate your daily job duties and any activities which you are occasionally asked to perform:
___ Standing ___ Driving ___ Sitting
___ Operating equipment ___ Twisting
___ Walking ___ Work with arms above head
___ Crawling ___ Typing ___ Lifting
___ Bending ___ 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? ___Y ___ N
___ N/A
Do you work with others who can help you with any heavy lifting? ___ Y ___ N
___ N/A
While in recovery, is there any light-duty work you could request? ___ Y ___ N
___ N/A

5b **AUTOMOBILE INSURANCE**
Please give your own automobile insurance information.
Company Name: _____
Phone #: _____
Insured's Name: _____
Policy #: _____ Claim #: _____
Agent's Name: _____
Please provide a copy of your automobile insurance card to the receptionist.

_____ _____ _____
Patient Name Print Patient Signature Date