# Discover Health Chiropractic, PLLC

*Reanna Plancich, D.C., NUCCA*

Motor Vehicle Collision

**General Information:**

Patient Name: _____
Date: _____
Date of Injury: _____
Marital Status: ❑M ❑S ❑W ❑D
Habits:
Smoke: ❑None ❑Social ❑Light ❑Mod. ❑Heavy
Employment:
At Time of Crash: _____
❑ Unemployed
Currently: _____
❑ Unemployed
Due to Crash? ❑Yes ❑No
Type of Work: ❑Office/Clerical ❑Light Labor ❑Moderate Labor ❑Heavy Labor

**Attorney Information:**

Attorney Name:_____
Phone Number:_____
Email:_____

**Insurance Information:**

Insurance:_____
Adjuster's Name:_____
Phone Number:_____
Claim Number:_____

**Past Medical History:**

Serious illness (dates and residual):
_____
_____
_____
Workers' comp. injuries (date, Treatment, residuals):
_____
_____
_____
Personal Injuries (date, treatment, residuals):
_____
_____
_____
Sports or other injuries to head, neck, or back:
_____
_____
Any prior history of Current Complaints:
1. _____
2. _____
3. _____

Prior treatment by chiropractor for these:
1. _____
2. _____
3. _____

**Current Medical History:**

Current Health Problems: ❑None
_____
_____
_____
Current medications taken: ❑None
_____
_____

**Injury History, General:**

Was the crash on-the-job? ❑Yes ❑No

You Were: ❑Driver ❑Front seat passenger ❑Rear seat passenger ❑Motorcycle operator ❑Motorcycle passenger
❑Other _____

Vehicle driven by: _____
Your vehicle (Yr, Make, Model): _____
Your estimated speed at moment of crash: _____
❑Stopped ❑Slowing ❑Accelerating
Other Vehicle (Yr, Make, Model):
_____
Time of Day: ❑Daylight ❑Dawn ❑Dusk ❑Dark
Road Conditions: ❑Dry ❑Damp ❑Wet Snow ❑Ice
❑Other_____
Head Restraints: ❑None ❑Integral Type
❑Adjustable Type ❑Up ❑Down ❑Don't Know
If adjustable, was the position altered by the crash? ❑Yes ❑No
Was the seat back adjustment altered by the crash? ❑Yes ❑No
Was the seat broken? ❑Yes ❑No
Lap Belt: ❑Wearing ❑Not Wearing ❑Don't Know
Shoulder Belt: ❑None ❑Wearing ❑Not Wearing ❑Don't Know
Did airbag deploy? ❑Yes ❑No
If yes, were you struck? ❑Yes ❑No
Body Position: ❑Good ❑Forward Lean
❑Other_____
Head Position: ❑Forward ❑Left ❑Right ❑Up ❑Down
Hands: ❑One on wheel ❑Two on wheel ❑N/A
Brakes Applied? ❑Yes ❑No

**Crash Description:**

_____
_____
_____
_____
_____
_____

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**Crash Diagram:**

Aware of impending crash? ❑Yes ❑No

**During Crash:**

Did you strike any parts of the vehicle? ❑Yes ❑ No
If Yes, Describe _____
Did vehicle strike any objects after crash? ❑Yes ❑No
If Yes, Describe _____
Wearing hats or glasses? ❑Yes ❑No
If Yes, still on after crash? ❑Yes ❑No
Did you lose consciousness? ❑Yes ❑No
If Yes, how long? _____
Estimated property damage to your vehicle:
$_____
Estimated damage to other vehicle(s):
❑None ❑Minimal ❑Moderate ❑Major
Were Police on scene? ❑Yes ❑No
If Yes, was report made? ❑Yes ❑No

**After The Crash:**

Symptoms: ❑Headache ❑Dizziness ❑Nausea
❑Confusion/Disorientation ❑Neck Pain ❑Paresthesia(s)
If Yes, where?_____
❑Extremity Pain. If Yes, where? _____
❑Back Pain
When did symptoms first appear? ❑Immediately
(describe which SX)_____ hr afterward
Where did you go after crash? ❑Home ❑Work
❑Hospital: _____
Mode of Transportation: _____
Pvt. Doctor: _____

**Emergency Department:**

Radiographs: ❑Yes ❑No
Body Parts imaged: _____
Results: _____
Lab Work ❑Yes ❑No ❑Cervical Collar ❑Ice
Medications: _____
Other: _____
Follow-up instructions: ❑None_____

**Treatment History:**

1.Dr.: _____
Specialty: _____ Date First Seen _____
Referred by: _____ TX Type: _____
TX Frequency:_____ TX Duration:_____
Currently treating? ❑Yes ❑No
Any disability? ❑Yes ❑No
If Yes, describe? ❑Yes ❑No
Special Tests:_____
Referred to:_____
Did TX help? ❑Yes ❑No
Notes:_____
_____

2.Dr.:_____
Specialty: _____ Date First Seen _____
Referred by: _____ TX Type: _____
TX Frequency:_____ TX Duration:_____
Currently treating? ❑Yes ❑No
Any disability? ❑Yes ❑No
If Yes, describe? ❑Yes ❑No
Special Tests:_____
Referred to:_____
Did TX help? ❑Yes ❑No
Notes:_____
_____

3. Dr.:_____
Specialty: _____ Date First Seen _____
Referred by: _____ TX Type: _____
TX Frequency:_____ TX Duration:_____
Currently treating? ❑Yes ❑No
Any disability? ❑Yes ❑No
If Yes, describe? ❑Yes ❑No
Special Tests:_____
Referred to:_____
Did TX help? ❑Yes ❑No
Notes:_____
_____

4. Dr.:_____
Specialty: _____ Date First Seen _____
Referred by: _____ TX Type: _____
TX Frequency:_____ TX Duration:_____
Currently treating? ❑Yes ❑No
Any disability? ❑Yes ❑No
If Yes, describe? ❑Yes ❑No
Special Tests:_____
Referred to:_____
Did TX help? ❑Yes ❑No
Notes:_____
_____

5. Dr.:_____
Specialty: _____ Date First Seen _____
Referred by: _____ TX Type: _____
TX Frequency:_____ TX Duration:_____
Currently treating? ❑Yes ❑No
Any disability? ❑Yes ❑No
If Yes, describe? ❑Yes ❑No
Special Tests:_____
Referred to:_____
Did TX help? ❑Yes ❑No
Notes:_____
_____

6. Dr.:_____
Specialty: _____ Date First Seen _____
Referred by: _____ TX Type: _____
TX Frequency:_____ TX Duration:_____
Currently treating? ❑Yes ❑No
Any disability? ❑Yes ❑No
If Yes, describe? ❑Yes ❑No
Special Tests:_____
Referred to:_____
Did TX help? ❑Yes ❑No
Notes:_____
_____

**Original Chief Complaints (if injury was not recent):**

1. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

2. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

3. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

4. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

5. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal:_____

**Current Chief Complaints:**

1. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

2. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

3. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

4. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

5. Body part/system:_____
Onset: _____
Provocative:_____
Palliative:_____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

**Self-Assessment as of today: % improved (list for separate areas)**

_____
_____
_____
_____

**Request Records:**

❑ 1. Request radiographs from:

_____
_____

❑ 2. Request records from:

_____
_____

❑ 3. Request copy of police report.

**Referral:**

❑ For: _____
To: _____

**Tests to Order:**

❑Radiographs: _____
❑Tomograms: _____
❑CT: _____
Area(s):_____
❑MRI:_____
Area(s):_____
❑MRA:_____
Area(s):_____
❑Scintigraphy/SPECT: _____
Area(s):_____
❑Videofluoroscopy:_____
Area(s):_____
❑EMG/NCV:_____
Root level/Nerve(s):_____
❑SEP: _____
Root level/Nerve(s):_____
❑Other Electrodiagnostic Test(s):_____
❑Ultrasound:_____
Area(s):_____

**Action Taken on this Visit:**

❑ Exam/TX: _____
_____
❑ Place on disability:_____
❑ Work restriction:_____
❑ Referral:_____
❑ Brace/collar:_____
❑ Home traction device: _____
❑ NEXERCICER:_____
❑ Supplements:_____
❑ Other:_____

Additional Notes: _____
_____
_____
_____
_____