Chiropractic Nutrition Clinic
2012 South Main St. Suite 508
Wake Forest, N.C. 27587
919-349-9413

REPORT OF INJURY

Patient Name_____
(PLEASE CHECK ALL THAT APPLY)

▶ List type of current accident:
Auto Accident ☐ When? ☐
Work Related ☐ When? ☐

▶ Were you hit from behind, head-on, side-swiped, or struck another vehicle?
▶ Describe what happened (ie: front, side rear impacts)
_____

▶ Any previous Auto accidents?
Yes ☐ No ☐ When? ☐ Did you receive treatment for that injury? ☐

▶ In the most recent Auto accident, were you the:
Driver ☐ Passenger ☐ Pedestrian ☐ On Bike ☐

▶ Please locate your position at the time of the accident:
Front Seat ☐ Rear Seat Passenger Side ☐ Rear Seat Driver Side ☐

▶ Were you:
Stopped and Struck From Behind ☐ Hit From Right Side ☐
Moving and Struck From Behind ☐ Hit From Left Side ☐
Stopped and Struck in Front-End ☐ Side Swiped ☐
Moving and Struck in Front-End ☐ Did more than one impact occur? ☐

▶ Were you wearing a seat belt
Yes ☐ No ☐

▶ Upon impact, which way was your head turned?
Left ☐ Right ☐ Ahead ☐

▶ Upon impact, did any portion of your body strike any objects in the car?
Yes ☐ No ☐

If YES, what portion of your body did you strike? Right or Left? (Please indicate R or L in box)
Head ☐ Knees ☐ Arms ☐ Hands ☐ Shoulders ☐ Other ☐_____

▶ What objects did you strike?
Steering Wheel ☐ Dash Board ☐
Side Window ☐ Left ☐ Right ☐ Rear View Mirror ☐
Side Door ☐ Left ☐ Right ☐ Windshield ☐
Center Console ☐ Headrest ☐
Can't Remember ☐
Other ☐_____

▶ **Were you**

Dazed ☐ Unconscious ☐ Cut (Where?) ☐ _____

Bruised (Where?) ☐ _____

Cuts/Scrapes (Where?) ☐ _____

Other Injuries not Listed Above? ☐ _____

▶ **Did you have:**

Momentary Deafness ☐ Loss of Balance ☐ Nausea ☐

Ringing in Ears ☐ Blurred Vision ☐ Dizziness ☐

Immediate Pain ☐ Gradual Pain ☐

▶ **Were the symptoms present before the accident?**

Yes ☐ No ☐

▶ **If Yes, please describe** _____

_____

▶ **What Hospital?**

WakeMed ☐ Rex ☐ Duke Health Raleigh ☐ Other ☐ _____

▶ **If you were taken to the Emergency Room Immediately, How?**

Ambulance ☐ Drove Yourself ☐ Taken by Someone ☐ Other ☐ _____

▶ **If you went home and later went to the Emergency Room or other Doctor?**

Date [_____] Hospital ☐ Doctor ☐ _____

▶ **Were you seen in the Emergency Room?**

Yes ☐ No ☐

▶ **Were you admitted to the Hospital?**

Yes ☐ No ☐

▶ **What procedure were done in the Emergency Room/Hospital?**

Examination ☐ Stitches ☐ X-Rays ☐ Neck Collar ☐ Brace ☐ Shot ☐

Pain Pills ☐ Muscle Relaxers ☐ Anti-Inflammatory ☐ Other ☐ _____

▶ **Are you taking any <u>other</u> medications currently, if yes, please list?**

Yes ☐ No ☐ _____

▶ **Have you seen any <u>other</u> Physicians for this problem, if yes, please name?**

Yes ☐ No ☐ _____

▶ **Are you pregnant?**

Yes ☐ No ☐

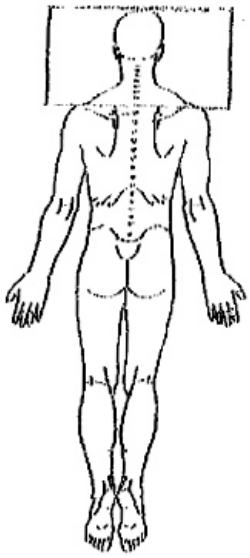
▶ **Patient's Signature:** _____ ▶ **Date:** _____

▶ **Doctor's Notes** _____

_____

Check symptoms you have noticed since accident.

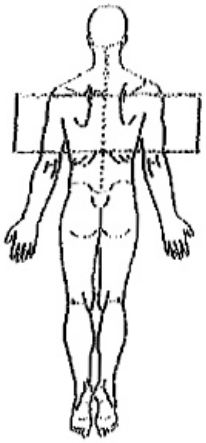
Head & Neck



- Neck Pain ☐
- Neck Stiffness ☐
- Neck Spasms ☐
- Headaches ☐
- Arm Pain ☐
- Pins/Needles in Arms ☐
- Numbness in Fingers ☐
- Hands Cold ☐
- Eyes Sensitive to Light ☐
- Dizziness ☐
- Head Seems too Heavy ☐
- Grinding Sensations in Neck ☐
- Loss of Balance ☐
- Loss of Memory ☐
- Nervousness ☐
- Fatigue ☐
- Sleeping Problems ☐
- Fainting Spells ☐
- Any Other Pain or Sensations? ☐ _____

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst) ☐

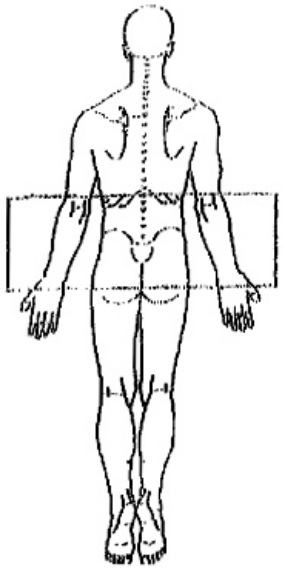
Mid-Back



- Mid Back Pain ☐
- Mid Back Stiffness ☐
- Mid Back Spasms ☐
- Pain in Ribs/Side ☐
- Any Other Pain or Sensations? ☐
- Shortness of Breath ☐
- Chest Pain ☐
- Breathing, Coughing, Sneezing Results in Increase of Pain ☐

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst) ☐

Low Back



- Low Back Pain ☐
- Low Back Stiffness ☐
- Low Back Spasms ☐
- Leg/Hip Pain ☐
- Pins/Needles in Legs ☐
- Any Other Pain or Sensations? ☐
- Numbness in Toes ☐
- Feet Cold ☐
- Breathing, Coughing, Sneezing Results in Increase of Pain ☐

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst) ☐