Auto Accident History Form

Amon Chiropractic Center PC **Dr. Richard P. Amon** 3996 South 1900 West, Roy, Utah 84067 801-731-2200

About You

Today's Date:_____

Patient:_____

Date of Birth: _____ □ Male □ Female

Address:_____

City: _____Zip:_____

Phone: _____Cell: _____

Email_____

Emergency Contact: Name – Phone:

_____

Insurance Information:
Utah is a No Fault State. Give us the info on both your insurance and the other.

Policy #_____

Claim #_____

Agent: _____Ph:_____

PIP coverage:_____

Name Ins. Co.:_____

Claim Billing Address:

_____

_____

Phone: _____

Other car's insurance info:

Name Ins. Co.:_____

Address:

_____

Additional Insurance:
PIP coverage is often used up at the ER.
Please list your **Medical Insurance Info:**

Insurance Co:_____

_____

Plan:_____

Policy# _____

Group # _____

Your Soc. Sec. # _____

Your Date of Birth:_____

Insured: _____

Employer:_____

Work Phone: _____

Address:_____

_____

The Accident

Date & Time of Accident: _____□am □pm

Number of vehicles involved: □ one □ two □ three □_____

Estimate in dollars the damage to your car:$_____

What road where you traveling on: _____

You were **traveling** □N □S □E □W □ Utah City:_____

Your vehicle was □ rearended □ rearended another □ hit your □ driver side □ passenger side □ rolled car over □ hit guardrail □ hit tree □ run off road □ _____

You were the: □ Driver □ Front Passenger □ Rear Passenger □Rt □Lt

You were □ unaware of the impending collision □ aware □ aware and braced for the collision

Your vehicle was a □ subcompact □ compact □ midsize □ SUV □ Pickup truck □ minivan □ Van □ larger than one ton vehicle

What type of vehicle hit you: a □subcompact □compact □midsize □ SUV □ Pickup □ minivan □ Van □ larger than one ton

At impact your car was: □ stopped □ slowing down □ speeding up □ driving at steady speed

At impact the other vehicle was: □ Slowing down □ Speeding up □ driving at steady speed □ stopped □ _____

After the crash your car: □ kept going straight □ kept going straight hitting car in front □ hit by another car □ spun around □ hitting a stationary object

Did you lose consciousness? □ No □ Yes …For how long _____

Your Head in accident was facing □ forward □ R □ L side □up □ downward: Your Body was turned □ right □ left

Your Hands were on the: □ steering wheel □ dash

Your Head hit the: □ windshield □ steering wheel □ side of car

Did your body part hit something at impact?
□ Head □ Face □ Shoulder □ Neck □ Chest □ Hips □ Knees □Feet

Are your Headrests? □fixed □moveable at level of □head □neck

Were you using your Seatbelt □Yes □No □Shoulder Strap □Lap

You □ Remained in Seatbelt □ Slid out of seat belt

What was damaged: □Bumper □Front □Rear □Side Door □R□L □ Windshield □Trunk □Seat…Dented in: □Frame □Doors□Dash

How did you go to **Hospital:** □Ambulance □Air □Drove self □ No

Choose Location of your Problems: □Headache □Jaw □Neck □ Upper Back □Shoulders □Arm □Elbows □Wrist □Hands □Mid Back □Low Back □Hip □Legs □Knees □Ankle □Foot

Pain Quality: □ Constant □Frequent □Occasional □Intermittent □Dull □Ache □Stiff □Sore □Local □Radiating □Arm □Leg □Shooting □Sharp on Motion□ Burning □Tingling □Getting Worse □ Getting Better □Staying the Same

Pain Level 0= No Pain !0= Excruciating 0 1 2 3 4 5 6 7 8 9 10

Interfered with work □Yes □ No Social Life □Yes □No

Do you consider pain to be: □Severe □ Moderate □ Mild

What makes the pain worse? □Bending □ Extending □ Driving □ Lifting □Twisting □Sleeping □Sitting □ Getting up □Stairs □Work □Computer work □Housework □Yard Work □Sports

What makes it Better? □Adjustments □Massage □Ice □Heat □Stretching □ Tynenol □Ibuprofen □Prescription Drugs □Rest □Laying Down □Exercising □_____

What concerns you most? □Getting worse □Staying Same □Affecting Work, □ Interfering with Activities?

If retaining Attorney: Name _____Address - Phone:

_____

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Describe how you felt Immediately after the accident: Did you feel: □ Stiff □ Sore □Headache □ Nervous □ Disoriented □ Dizzy/dazed □ Nauseous □ Weak □ Other

Indicate the symptoms that are a result of this accident? □ Dizziness □Difficulty sleeping □Jaw problems□Memory Loss □ Nausea □ Irritability □ Back pain □ Headaches □Tension □ Arm/Shoulder pain □ Fatigue □ Neck pain □ Neck stiff □ Numb Hands/Fingers □ Lower back pain □ Leg pain □ Numb Feet/Toes □ Back stiffness □ Chest pain □ Buzzing/Ringing in Ear □ Shortness of breath □ Stomach upset □ Ears ringing □ Blurred vision □ Other:_____

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		□ Other _____
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		_____
□	□ Chronic Sinusitis	□	□ Dizziness		

Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Cancer □ Lupus □ ALS □ Heart Problems _____

List all prescription medications you are currently taking:

_____

List all of the over-the-counter medications or supplements you are currently taking:

_____

List all surgical procedures you have had:

_____

Have you ever been hospitalized? □ No □ Yes if yes, when why _____

Have you had significant past trauma? □ No □ Yes _____

List Any & All Previous Auto Accidents with Dates and if you still suffer from effects of such: _____

_____

What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

What activities do you do outside of work?
Your Exercise Level: □Strenuous □ Moderate □ Light
□ Walk □ Run □ Golf □ Weights □ Yard work □ Sports
_____
_____

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. □ Sitting □ Typing □Twisting □ Driving □ Standing □ Operating Equipment □ Walking □ Crawling □ Stooping □ Bending □ Work with arms above head □ Lifting pounds?_____
What positions can you work in with minimum physical effort and for how long? _____□ N/A

Prior to injury were you capable of working on an equal basis with others? □Yes □ No While in recovery, is there light duty you could request?□Yes □No

I testify that the history is true and correct. If any of my medical or account information has changed I will inform the front desk. I realize that I am ultimately responsible for my account. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services. I authorize release of any medical information necessary to process my claim and request payment of insurance benefits to be made to you.

Date: _____ Patient: _____