CURA CHIROPRACTIC

11138 NE Halsey Street
Portland, OR 97220
Phone: (503) 575-9934

Injury Intake Form

ACCIDENT HISTORY: **Name:**_____

Date of accident____/____/_____ Time of accident_____ am / pm Daylight Dawn Dusk Dark

Road conditions at the time of accident Wet Dry Snow Ice Other_____

Did this accident occur during a job? Yes No If yes, were you in a company vehicle? Yes No

Where were you seated in the vehicle? Driver front passenger Rear passenger

Name of Driver if you're a passenger _____

Was there anyone else in the car? Y N Name_____

Were you aware of the approaching collision prior to impact or were you surprised? Aware Surprised

Did you brace for the impact? Y N

Did you lose consciousness upon impact? Yes No If yes, how long _____

Did you experience a flash of light or an 'explosion' in your head? Yes No

Did the police come to the scene of the accident? Yes No If yes, Accident report file? Yes No

Were you wearing a seatbelt? Yes No If yes, did you receive any injury or bruising from the seatbelt? Yes No

What happened to you at the time of the impact? (head hit headrest?, etc.) _____

Did any part of your body strike any object inside the car? Y N if yes, explain _____

Did the car seat break or adjustment alter by the accident? Yes No

Did the airbag deploy? Yes No If yes, did it strike you? Yes No If yes, where? _____

Which way was your head pointing at the time of impact? Straight Down Right Left

Which way was your body pointing at the time of impact? Straight Down Right Left

Where were your hands? One on the wheel Both on the wheel Not driver Other _____

Were you wearing a hat, wigs or glasses at the time of impact? Yes No If yes, were they still on after impact? Y N

What happened after the accident? Arrange for ride home or Continue w/ activity, transport to local hospital?

Was your car towed from the scene? Y N

Did you go to the doctor/other clinic before today? Y N If yes, when? □ Immediately □ hours later □ days later

Name of the doctor/clinic? _____ How did you get there? _____

What did the doctor/clinic do for your injuries? (collars, splints, x-rays, medication, surgery, etc.)

_____

_____

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Were you examined? Yes No Were any X-ray, MRI, or CT scan taken? Yes No

What areas were x-rayed? _____ What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? Yes No If yes, please complete information below:

Dr. _____ Specialty: _____ Date first seen: _____

Type of treatment: _____ Treatment frequency: _____

Are you still receiving treatment? _____

State how the accident happened in your own words:

_____

_____

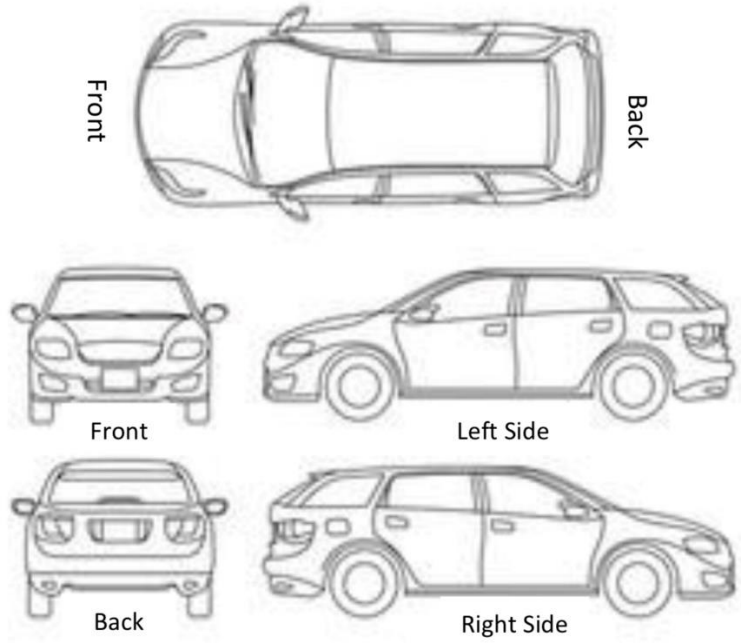
_____

_____

_____

Please indicate where your car was damaged to the best of your ability. Do you know what is the damage estimates?

Mark the area that was damaged:



Your Vehicle

Please list he year, make and model of the car you were in: Year _____ Make_____ Model_____

Was your car stopped at the time of impact? Yes No If Yes, was the driver foot on the brake? Y / N

What is the estimated speed of the vehicle ____mph.

Estimate Damage of your vehicle? No damage, slight moderate damage, or significant visible damage?

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If the vehicle was moving at the time of impact, was it: □ Slowing down □ Gaining speed □ Steady speed

Did the collision move your vehicle? Y N If yes, how far? _____

OTHER VEHICLE

Please list the year, make and model of the other car: Year _____ Make_____ Model_____

Was the other vehicle moving at the time of impact? Yes No

What is the estimated speed of the vehicle ____mph. Est damage? No visible, slight moderate, significant visible damage

At the time of the impact, the other car was: □ Slowing down □ Gaining speed □ Steady speed

Immediately after the accident did you become or experience any of the following?

□ Disoriented □ Dizzy □ Confused □ Nauseated □ Lightheaded □ Blurred vision

□ Loss of balance □ Ringing /Buzzing in the Ears □ Vomited □ Shock □ Dazed
Other: _____

Could you move all parts of your body? □ Yes □ No

If no, explain: _____

Could you exit the car unaided after the accident? □ Yes □ No

Since the accident, are your symptoms getting? □ better □ worse □ the same

CURRENT COMPLAINTS

Please check any of the symptoms below you have noticed since the accident:

☐ Disoriented ☐ Confused ☐ Nauseated ☐ Headaches/Migraines

☐ Neck Pain ☐ Upper Back Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Shoulder Pain

☐ Depression ☐ Buzzing in Ears ☐ Arm/Leg Pain ☐ Jaw Pain/Clicking ☐ Dizziness

☐ Fatigue ☐ Loss of Memory ☐ Cold Hands/Feet ☐ Numbness/Tingling ☐ Loss of Smell

☐ Irritability ☐ Joint Pain/Stiffness ☐ Menstrual Problems ☐ Pinched Nerve

☐ Loss of Balance ☐ Chest Pain ☐ Sensitivity to Light ☐ Fever

☐ Nervousness ☐ Vision Problems ☐ Urinary Problems ☐ Sleeping Problems ☐ Paralysis

☐ Tension ☐ Fainting ☐ Pins/Needles Feeling ☐ Upset Stomach ☐ Difficulty Swallowing

☐ Sciatica ☐ Sinus Pain ☐ Sore Muscles ☐ Head Feels Too Heavy ☐ Other: _____

Symptoms:

Location of your pain: □ Headache □ Neck □ Shoulders □ Upper Back □ Low Back □ Arms □ Legs □ Other:

_____

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_____

_____

SPECIFIC AREAS OF COMPLAINT

1. **Body Part**: _____ Date symptom first appeared: _____
   How often do you experience these symptoms?
   □ **Constant 100%** □ **Frequent 75%** □ **Intermittent 50%** □ **Occasional25%** □ **Rare 10%**
   What activity makes these symptoms increase? _____
   What activity makes these symptoms decrease? _____
   Types of pain? □ **Sharp** □ **Dull** □ **Aching** □ **Burning** □ **Throbbing** □ **Stabbing** □ **Pulsing** □ **Numbness**
   Stiffness, Tight Other: _____
   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)
   0 1 2 3 4 5 6 7 8 9 10
   If the pain radiates, where does it radiate to?
   _____
2. **Body Part:** _____ Date symptom first appeared: _____
   How often do you experience these symptoms?
   □ **Constant 100%** □ **Frequent 75%** □ **Intermittent 50%** □ **Occasional25%** □ **Rare 10%**
   What makes these symptoms increase? _____
   What makes these symptoms decrease? _____
   Types of pain? □ **Sharp** □ **Dull** □ **Aching** □ **Burning** □ **Throbbing** □ **Stabbing** □ **Pulsing** □ **Numbness**
   Other: _____
   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)
   0 1 2 3 4 5 6 7 8 9 10
   If the pain radiates, where does it radiate to?
   _____
3. **Body Part**: _____ Date symptom first appeared: _____
   How often do you experience these symptoms?
   □ **Constant 100%** □ **Frequent 75%** □ **Intermittent 50%** □ **Occasional25%** □ **Rare 10%**
   What makes these symptoms increase? _____
   What makes these symptoms decrease? _____
   Types of pain? □ **Sharp** □ **Dull** □ **Aching** □ **Burning** □ **Throbbing** □ **Stabbing** □ **Pulsing** □ **Numbness**
   Other: _____
   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)
   0 1 2 3 4 5 6 7 8 9 10
   If the pain radiates, where does it radiate to? _____

Other body parts affected (shoulders, knees, head, wrists, etc.)? _____

Any other additional information: _____

_____

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OCCUPATIONAL INFORMATION

What is your occupation? What is your work schedule like? Full time Part-time

Physical activity at work: □ Sedentary □ Light, manual labor Manual labor □ Intense, manual labor

Have you missed any time from work due to the accident? □ Yes □ No If yes, how many days? _____

Do any of your work activities aggravate your current complaints? □ Yes □ No If yes, please explain: _____

Job involves: □ Sitting □ Standing How long? _____ Lifting How much? _____ lbs.

□ Bending □ Twisting □ Turning □ Stooping

PAST HEALTH /SOCIAL HX

Any serious illnesses or conditions? Y N If yes, explain_____

Have you been hospitalized? Y N If yes, explain _____

Have you ever had any surgeries? Y N If yes, explain _____

Have you experienced any previous physical trauma? Y N

Are you currently taking any medications? Y N If Yes, name, dosage and what it is for _____

Have you had any other accidents? Y N

Have you ever had any X-ray before? Y N _____

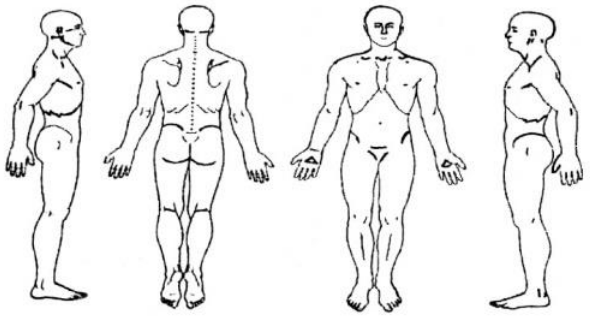
Do you drink? Y N If yes, how much? How often? _____

Do you use tobacco? Y N If Yes, how much? How long? _____

Is there anything run in your family such as: Diabetes, High blood pressure (BP), low BP, stroke, Asthma, heart disease, cancer, etc.

Please mark the image where you are feeling pain or discomfort. →

OFFICE USE ONLY
Height:
Weight:
Blood Pressure:
Pulse:



I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____/_____/_____