

# Auto Accident Report

Bryan Bingham DC  
3531 NE 15th Ave Ste. E, Portland, OR 97212  
503.546.9987 fax 503.546.9988

Name: \_\_\_\_\_ Date of accident: \_\_\_\_\_

Please describe or sketch the accident:

Year/make/model of your car: \_\_\_\_\_ other car: \_\_\_\_\_

Total # cars involved: \_\_\_\_\_ Est. speed of your car: \_\_\_\_\_ other car: \_\_\_\_\_

Were you hit from:  Front  Back  Right side  Left side

Were your brakes applied?  yes  no Was your car:  automatic  manual transmission

Were you:  driver  passenger Were you wearing:  lap belt  shoulder belt

Were you aware of the impending collision?  yes  no Road conditions were: \_\_\_\_\_

Did you hit anything on the inside of the car? \_\_\_\_\_

Was there more than one impact? \_\_\_\_\_ How many did you feel? \_\_\_\_\_

Were there:  Multiple vehicular impacts  Impacts with road barriers (poles, trees, barriers, etc.)

Were you knocked unconscious or dazed? ( circle answer) For how long? \_\_\_\_\_

Describe your head position at the time of the impact: \_\_\_\_\_

Did you notice any bruising/swelling? Where? \_\_\_\_\_

Have you been examined/treated since the accident (Hospital ER, Dr., etc): \_\_\_\_\_

Was an accident report made? \_\_\_\_\_ Est. of auto damage: \$ \_\_\_\_\_ Was your car drivable? \_\_\_\_\_

Have you lost work time as a result of your injuries? \_\_\_\_\_ How much? \_\_\_\_\_

Have you had any previous accidents resulting injury/treatment? \_\_\_\_\_

## INSURANCE INFORMATION:

Your Health Insurance Co. \_\_\_\_\_

Address: \_\_\_\_\_ Policy # \_\_\_\_\_

Your Auto Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Address: \_\_\_\_\_ Adjuster: \_\_\_\_\_

Phone #: \_\_\_\_\_ Have you reported this accident? \_\_\_\_\_

Other Party's Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Address: \_\_\_\_\_ Adjuster: \_\_\_\_\_

Phone #: \_\_\_\_\_ Have you been contacted? \_\_\_\_\_

Has an attorney advised you in this matter? \_\_\_\_\_ Are you being represented? \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_

**CONFIDENTIAL CASE HISTORY FILE**

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page 1 of 2

Date: \_\_\_\_\_  
Full Legal Name: \_\_\_\_\_ Name you prefer: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Phone: (home) (\_\_\_\_) \_\_\_\_\_ (work) (\_\_\_\_) \_\_\_\_\_ Soc Sec# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: S M W D Sep  
Spouse's Name: \_\_\_\_\_ # Children \_\_\_\_\_ Years of Education \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Your Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Job title: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_  
e-mail address: \_\_\_\_\_ Referred by: \_\_\_\_\_

**MEDICAL HISTORY** (please be complete)

List any surgeries (include dates & reason): \_\_\_\_\_  
List any hospitalizations (include dates & reason): \_\_\_\_\_  
List any auto accident injuries (include dates): \_\_\_\_\_  
List any on the job injuries (include dates): \_\_\_\_\_  
List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.): \_\_\_\_\_

List all current over-the-counter and prescription medications used (include reason used): \_\_\_\_\_

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.) \_\_\_\_\_

Have you been under a physician's care in the past year?  no  yes (reason) \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_ Dr: \_\_\_\_\_

Have you ever been under chiropractic care?  no  yes (describe) \_\_\_\_\_

If female, is there a possibility that you are pregnant?  no  yes

Do you smoke/use tobacco?  no  yes Exercise habits?  never  occasional  frequent

Check any of the following symptoms you have noticed: (  = Previously,  = Now)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Low back pain                   | <input type="checkbox"/> Sensitive to light or sound                          |
| <input type="checkbox"/> Dizziness or light-headed      | <input type="checkbox"/> Leg/foot numbness/tingling      | <input type="checkbox"/> Visual or hearing disturbance                        |
| <input type="checkbox"/> Jaw pain, clicking, or locking | <input type="checkbox"/> Leg/foot fatigue/weakness       | <input type="checkbox"/> Memory loss/problems                                 |
| <input type="checkbox"/> Pain or difficulty swallowing  | <input type="checkbox"/> Leg pain with walking           | <input type="checkbox"/> Irritability or depression                           |
| <input type="checkbox"/> Neck pain or stiffness         | <input type="checkbox"/> Abdominal pain                  | <input type="checkbox"/> Fatigue or loss of energy                            |
| <input type="checkbox"/> Shoulder pain                  | <input type="checkbox"/> Nausea or vomiting              | <input type="checkbox"/> Fainting or convulsions                              |
| <input type="checkbox"/> Mid back pain                  | <input type="checkbox"/> Diarrhea or constipation        | <input type="checkbox"/> Trouble with balance or coordination                 |
| <input type="checkbox"/> Chest pain or cough            | <input type="checkbox"/> Blood in urine or stool         | <input type="checkbox"/> Sleep disturbances/problems                          |
| <input type="checkbox"/> Pain/trouble breathing         | <input type="checkbox"/> Difficulty or pain w/ urination | <input type="checkbox"/> Rashes (face, body, limbs)                           |
| <input type="checkbox"/> Arm/hand numbness/tingling     | <input type="checkbox"/> Difficulty with sexual function | <input type="checkbox"/> Joint pain or swelling                               |
| <input type="checkbox"/> Arm/hand fatigue/weakness      | <input type="checkbox"/> Abnormal menstrual periods      | <input type="checkbox"/> Pain with exertion (activity, climbing stairs, etc.) |

<b>HAVE YOU HAD ANY OF THE FOLLOWING:</b>	<b>NOW:</b>	<input type="checkbox"/> Recent bacterial infection (30 days)	<b>EVER:</b>
	<input type="checkbox"/> Pain worse at night	<input type="checkbox"/> Loss of bowel or bladder control	<input type="checkbox"/> History of cancer
	<input type="checkbox"/> Constant pain	<input type="checkbox"/> Urinary discharge	<input type="checkbox"/> History of IV drug use
	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Recent surgery (30 days)	<input type="checkbox"/> History of blood transfusion

# Information about your current condition/complaints

What is your primary complaint/problem? \_\_\_\_\_

List other symptoms: \_\_\_\_\_

When did your symptoms first begin (give date if possible)? \_\_\_\_\_

How did your symptoms first begin? \_\_\_\_\_

Pain is:  Constant  Intermittent

Is your condition getting worse? \_\_\_\_\_

What activities aggravate your condition? (list) \_\_\_\_\_

What activities lessen your symptoms? (list) \_\_\_\_\_

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Have you had:  Xray  MRI or CAT Scan  EMG  Bone Scan  Blood Work

Who is your family medical doctor: \_\_\_\_\_

List all home remedies tried for this problem: \_\_\_\_\_

Is your condition worse at certain times of the day or night? \_\_\_\_\_

Does your condition interfere with: (yes/no) work \_\_\_\_\_ sleep \_\_\_\_\_ normal daily routine \_\_\_\_\_

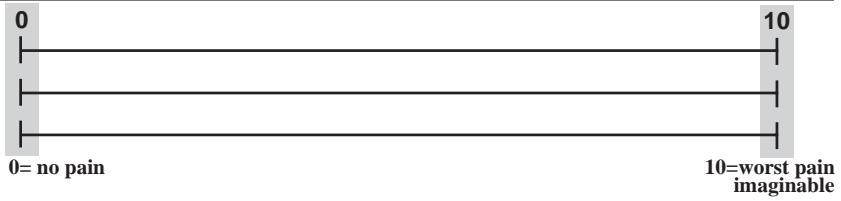
Have you had symptoms like this before?  no  yes (describe) \_\_\_\_\_

*Regarding your main complaint:*

1. RIGHT NOW:

2. AVERAGE:

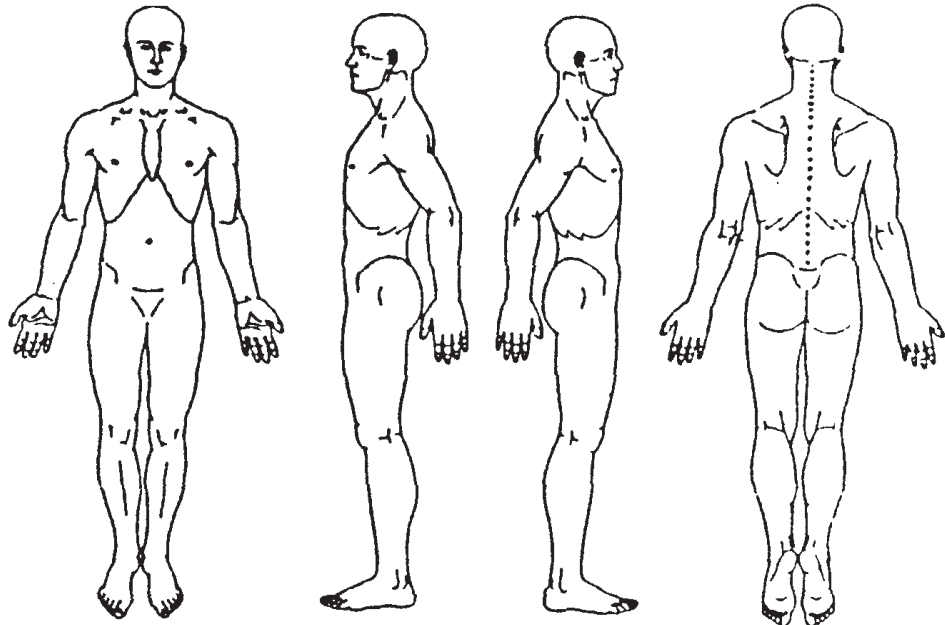
3. AT WORST:



How bad is your pain?  
(make a slash on all 3 scales)

Draw the area of your symptoms using these symbols:  
(mark on the figures)

- XXX = ache
- \* = sharp/stab
- ooo = numb/tingle
- = shooting
- //// = stiff/tight



**NOTICE TO NEW PATIENTS:** Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_