Bryant Chiropractic and Massage
1150 140th Ave. NE, Suite 101
Bellevue, WA 98005
Phone: 425- 890- 0142; Fax: 425- 412- 4949
Dr. Randy Bryant, DC, Ekaterina Bryant, LMP

Motor Vehicle Accident History

Patient Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ AM / PM

Accident Description: _____

_____

_____

_____

Were you the: _____ Driver _____Front Passenger _____Rear Passenger ____ Pedestrian

How many people were in the vehicle at the time? _____ Vehicle Driven by: _____

ACCIDENT DIAGRAM

ACCIDENT SITE

Road/Street Name: _____

City/State: _____

Nearest intersection with road/street: _____

Driving condition: ____Dry ____Wet ____Icy ____Other

POLICE

Did the police come to the accident site? _____Yes ____ No
Were there any witness? ____Yes ____No
Was a police report filed? ____Yes ____No
Was a traffic violation issued? ____Yes ____No If yes, to whom? _____

PATIENT'S VEHICLE

Make and model of vehicle you were in? _____

Head restraints: ____ None ____Integral type ____ Adjustable type

Was head restraint: ____ Up ____ Down Did the seat or anything else break? ____Yes ____No

Were you wearing a seatbelt? ____Yes ___ No If yes, what type? ____Lap ____ Shoulder

Did airbag deploy? ____Yes ____No If yes, were you struck? ____Yes ____No

Approximate speed of your vehicle: _____ Approximate property damage: _____

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OTHER VEHICLE(S)
(If Applicable)

Make and model of the other vehicle(s):_____

Direction of other vehicle(s): _____ Approximate Speed of vehicle: _____

IMPACT

Did your car impact another vehicle other than 3rd party? ____ Yes ____ No

If yes, describe: _____

Did your car impact any type of structure? ____ Yes ____No If yes, explain _____

_____

Did any part of your body strike anything in the vehicle? ____ Yes ____ No

If yes, explain: _____

Was impact from: ____Front ____ Rear ____ Left ____Right ____Other _____

At the time of impact what was your body position? _____

In what position were your hands? _____

Was your foot on the brake? ___ Yes ____No ____N/A If yes, which foot? ____Right ____Left

Where you wearing anything that fell off due to the impact? ____Yes ____No

If yes, what?_____

Were you holding anything at the time of impact? ____Yes ____No What:_____

PATIENT CONDITION

Was consciousness lost immediately following the accident? ____Yes ____No

If yes, for how long? _____ Symptoms following the accident were: _____

_____

_____

_____

_____

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TREATMENT RECEIVED

Did you go to the hospital/clinic? ____Yes ____No Name of Hospital_____

When did you go?____Immediately after the accident ____Next Day ____2 days or more after MVA

How did you get there? ____Ambulance ____ Private transportation

Treatment received/Medications: _____

X-rays taken: ____Yes ____No Part of body imaged: _____

Lab work: ____Yes ____No _____Cervical collar ____Ice

SYMPTOMS/INJURIES

Have you been able to work or attend school since this accident? ____Yes ____No

How many work/school days have you missed? _____

Have you have any of the following symptoms since your injury?

____ Shortness of breath	**____ Shoulder pain R/L/B**	**____Feet/toe numbness R/L/B**
____ Neck pain	**____ Chest pain R/L/B**	**____Hand/finger numbness R/L/B**
____ Neck stiffness	**____ Back stiffness**	**____Arm pain/numbness R/L/B**
____ Back pain	**____ Memory loss**	**____Leg pain R/L/B**
____ Dizziness	**____ Nausea**	**____Blurred Vision R/L/B**

____ Headaches R/L/Front/Back Other: _____

Is the condition getting progressively worse? ____Yes ____No ____Unknown

Type of pain: ____Sharp ____Dull ____Throbbing ____Aching ____Shooting ____Burning

____Tingling ____Cramps ____Stiffness ____Swelling ____Tiredness ____Other:_____

How frequent if your pain?

____ Intermittent – Pain occurs less than 25% of waking hours

____ Occasional – Pain occurs 25% to 50% of waking hours

____ Frequent – Pain occurs 50% to 75% of waking hours

____ Constant – Pain occurs 75% to 100% of waking hours

Does it interfere with your:

____Work

____Sleep

____Daily routine

Activities/movements painful to perform:
___Sitting ___Standing ___Walking ___Bending ___ Lying down ___Other _____

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FAMILY HISTORY

Parents: Mother ____alive ____deceased Father ___alive ___deceased

Cause of death_____

Diseases in the family _____

SOCIAL HISTORY

Marital status _____Children_____ Use of drugs/alcohol/tobacco _____

Occupation_____ Level of Education: _____

Females: Are you taking any oral contraceptives? _____

PAST MEDICAL HISTORY

Prior major illness/injuries/allergies _____

_____

Prior operations/hospitalizations _____

_____

Prior auto accident/work injuries _____

_____

Current medication prescription/over the counter _____

The statements made in these documents are true and accurate to the best of my recollection.

Signature _____ Date _____CT Initials _____
(Patient or Legal Guardian)

Weight: _____lbs Height: _____ BP: (R) (L) _____ Pulse: _____

Additional Notes: _____

_____

_____

_____

_____