

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

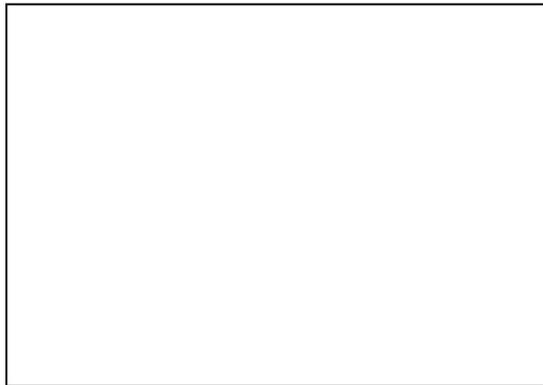
Accident Description: _____

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: _____
