BACK TO HEALTH CHIROPRACTIC
120 TOMPKINS ST.
CORTLAND, NEW YORK 13045
(607) 753-1884 FAX: (607) 753-1540
DONNA LIEBERMAN, DC **HOWARD LIEBERMAN, DC**

MOTOR VEHICLE ACCIDENT HISTORY

NAME: _____ SSN: _____

Address: _____

Employer: _____ Employer Address/Tele # _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____
CELL#
AUTO INSURANCE CO: _____ PHONE# _____

LOCAL INSURANCE AGENT: _____ PHONE#: _____

POLICY HOLDERS'S NAME (If other than self): _____

POLICY#: _____ CLAIM#: _____

MAKE OF CAR: _____ YEAR: _____

ATTORNEY NAME: _____ PHONE#: _____

DATE OF ACCIDENT _____ TIME OF ACCIDENT _____

WERE YOU THE (circle) DRIVER / PASSENGER / PEDESTRIAN / CYCLIST / OTHER _____
WERE YOU SEATED IN THE (circle) FRONT / BACK / OTHER _____
WERE YOU WEARING SEATBELT? Y / N DID YOUR AIR BAG DEPLOY? Y / N / NO AIRBAG
NAME OF STREET YOU WERE ON _____ SPEED OF CAR ____
WHAT DIRECTION WERE YOU HEADING (circle) NORTH/SOUTH/ EAST/ WEST
WHAT DIRECTION OF OTHER VEHICHLE (circle) NORTH / SOUTH / EAST / WEST
NAME OF STREET OTHER VEHICLE ON _____ SPEED OF OTHER CAR ____

WERE YOU KNOCKED UNCONSCIOUS? Y/N FOR HOW LONG _____
_____ ANY TICKETS ISSUED? Y/N TO WHOM _____
_____

PLEASE DESCRIBE THE ACCIDENT:

_____

_____

_____

WHERE WERE YOU TAKEN ***AFTER*** THE ACCIDENT?(circle) HOME/HOSPITAL/OTHER
HOW DID YOU GET THERE?(circle) DROVE SELF/AMBULANCE/SOMEONE ELSE DROVE
SINCE THE ACCIDENT YOU ARE FEELING (circle) IMPROVED/UNCHANGED/GETTING WORSE
DID YOU LOSE TIME FROM WORK DUE TO THE ACCIDENT? (circle) Y/N/NOT EMPLOYED
ARE YOU STILL OUT OF WORK? Y/N DATE LAST WORKED _____
MOST OF WORK DAY I (circle) SIT/STAND/SIT AND STAND EQUALLY/WALK/ LIFT
DID YOU HAVE ANY PHYSICAL COMPLAINTS ***BEFORE*** THE ACCIDENT? Y/N
(if yes,please explain)

_____

_____

MOTOR VEHICLE ACCIDENT HISTORY CONTINUED

SINCE THE ACCIDENT HAVE YOU HAD ANY (circle) ACCIDENTS/INJURIES/ILLNESSES? (please explain)

_____

_____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR/PHYSICAL THERAPIST FOR THIS INJURY? PLEASE LIST NAME(S)/CITY

_____

_____

DID THESE TREATMENTS HELP? Y/N/NOT SURE
DO YOU SMOKE? Y/N _____PACK/DAY SUBSTANCE ABUSE? Y/N _____
HAVE YOU EVER BEEN TREATED FOR A MENTAL ILLNESS? Y/N (if yes, please explain)

_____

IN YOUR ***LIFETIME***, HAVE YOU EVER HAD ANY (circle) ACCIDENTS/ILLNESSES WHICH HAVE REQUIRED (circle) MEDICAL CARE/CHIROPRACTIC CARE/ HOSPITALIZATION/ SURGERY (please describe)

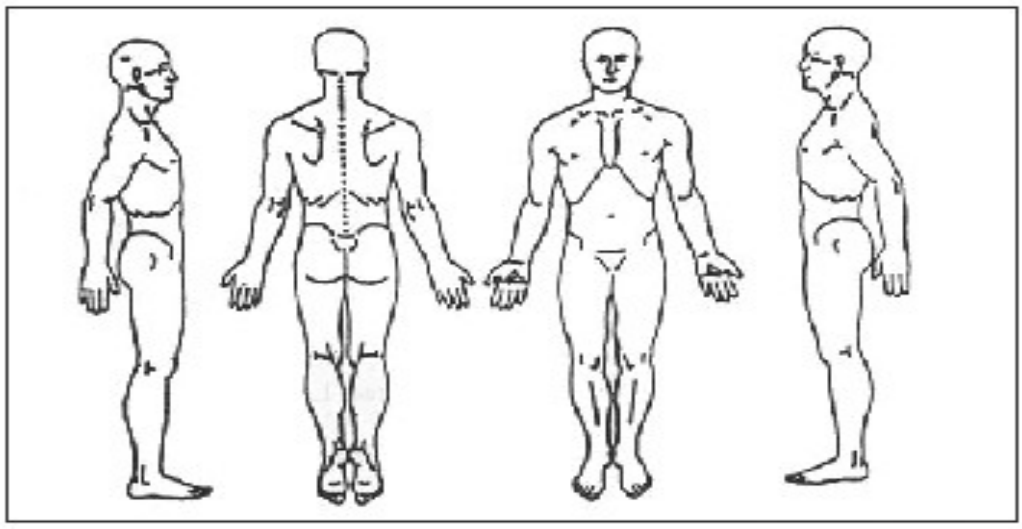
_____

_____

WHAT MAKES YOUR PROBLEM/ PAIN WORSE? (please circle all that apply)
COUGH/SNEEZE/BOWEL MOVEMENT/SIT/STAND/BEND/WALK/LIFT/PUSH/PULL/DRIVE / SEXUAL ACTIVITY/CHANGE IN THE WEATHER/PAIN WAKES ME UP AT NIGHT/OTHER _____

_____

WHAT MAKES YOUR PROBLEM/PAIN BETTER? (please circle all that apply)
WALK/STAND/SIT/LYING DOWN/EXERCISE/MOVEMENT/MOIST HEAT/ICE/SHOWER/HOT BATH/NOTHING/OTHER _____
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN, INCLUDE NUMBNESS OR TINGLING



RATE YOUR CURRENT PAIN ON SCALE 1-10 (please circle a number)

1 2 3 4 5 6 7 8 9 10
(no pain) (unbearable pain)

Who referred you to our office? _____

SIGNATURE:_____ DATE:_____ 2/17/20