



Kuzma Chiropractic

Your wellness resource

CAD Injury History Form

Today's Date: _____

Patient's Name: _____ Date of Injury: _____

General Information

Marital status: M S W D

Habits: Smoke: None Pk/day _____ Years _____

Alcohol: Never Social Light

Moderate Heavy

Employment:

At time of crash: _____ Unemployed

Currently: _____ Unemployed

Due to crash? Yes No

Type of work: Office/clerical Light labor

Moderate labor Heavy labor

Past Medical History

Surgeries (dates and residuals): _____

Sports or other injuries to head, neck, or back: _____

Fractures (dates and residuals): _____

Any prior HX of current complaints:

1. _____

2. _____

3. _____

Serious illness (dates and residuals): _____

Prior TX by DC for these:

1. _____

2. _____

3. _____

Workers' comp. injuries (date, TX, awards, residuals): _____

Current Medical History:

Current Health Problems: None

Personal Injuries (date, TX, awards, residuals): _____

Current medications taken: None

Injury History

Was the crash on-the-job? Yes No

If adjustable, was the position altered by the crash?

You were: Driver Front seat passenger

Yes No

Rear seat passenger Motorcycle operator

Was the seat back adjustment altered by the crash?

Motorcycle passenger Other

Yes No

Vehicle driven by: _____

Was the seat broken? Yes No

Your vehicle (year, make, model): _____

Lap belt: Wearing Not wearing Don't know

Your estimated speed at moment of crash: _____

Shoulder belt: None Wearing Not wearing

Stopped Slowing Accelerating

Don't know

Other vehicle (year, make, model): _____

Did air bag deploy? Yes No

Time of day: Daylight Dawn Dusk Dark

If yes, were you struck? Yes No

Road conditions: Dry Damp Wet Snow

Body position: Good Forward lean

Ice Other _____

Other _____

Head restraints: None Integral type Adjustable type:

Head position: Forward Left _____°

Up Down Don't know

Right _____° Up _____° Down _____°

Hands: One on wheel Two on wheel N/A

Brakes applied? Yes No

Crash description: _____



Crash Diagram

Aware of impending crash? Yes No

During the Crash:

Did you strike any parts of the vehicle? Y N

If yes, describe _____

Did vehicle strike any objects after crash? Y N

If yes, describe _____

Wearing hat or glasses? Y N

If yes, still on after crash? Y N

Did you lose consciousness? Y N

If yes, for how long? _____

Estimated property damage to your vehicle: \$ _____

Estimated damage to other vehicle(s):

None Minimal Moderate Major

Were the police on-scene? Y N

If yes, was a report made? Y N

After the Crash:

Symptoms: Headache Dizziness Nausea

Confusion/disorientation Neck pain Paresthesia(s)

If yes, where? _____

Extremity pain. If yes, where? _____

Back pain

When did SX first appear? Immediately

(describe which SX) _____ hr afterward

Where did you go after crash? Home Work

Hospital: _____

Mode of transportation: _____

Pvt. doctor: _____

Emergency Department:

Radiographs: Yes No

Body parts imaged

Results

Lab work Yes No _____

Cervical collar Ice

Medications: _____

Other: _____

Follow-up instructions: None _____

Treatment History

1. Dr.: _____

Specialty: _____ Date first seen: _____

Referred by: _____ TX type: _____

TX frequency: _____ TX duration: _____

Currently treating? Y N

Any disability? Y N

If yes, describe: _____

Special tests: _____

Referred to: _____

Did TX help? Y N

Notes: _____

2. Dr.: _____

Specialty: _____ Date first seen: _____

Referred by: _____ TX type: _____

TX frequency: _____ TX duration: _____

Currently treating? Y N

Any disability? Y N

If yes, describe: _____

Special tests: _____

Referred to: _____

Did TX help? Y N

Notes: _____

3. Dr.: _____

Specialty: _____ Date first seen: _____

Referred by: _____ TX type: _____

TX frequency: _____ TX duration: _____

Currently treating? Y N

Any disability? Y N

If yes, describe: _____

Special tests: _____

Referred to: _____

Did TX help? Y N

Notes: _____

4. Dr.: _____

Specialty: _____ Date first seen: _____

Referred by: _____ TX type: _____

TX frequency: _____ TX duration: _____

Currently treating? Y N

Any disability? Y N

If yes, describe: _____

Special tests: _____

Referred to: _____

Did TX help? Y N

Notes: _____

5. Dr.: _____

Specialty: _____ Date first seen: _____

Referred by: _____ TX type: _____

TX frequency: _____ TX duration: _____

Currently treating? Y N

Any disability? Y N

If yes, describe: _____

Special tests: _____

Referred to: _____

Did TX help? Y N

Notes: _____

Original Chief Complaints:

(if injury was not recent):

1. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

2. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

3. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

4. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

5. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

Current Chief Complaints:

1. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

2. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

3. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

4. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

5. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

Self Assessment as of Today: % Improved

(List for separate areas)

Request Records:

1. Request radiographs from: _____

2. Request records from: _____

3. Request copy of police report. _____

Referral:

For: _____

To: _____

Tests to Order:

Radiographs: _____

Tomograms: _____

CT: _____

Area(s): _____

MRI: _____

Area(s): _____

MRA: _____

Area(s): _____

Scintigraphy/SPECT: _____

Area(s): _____

Videofluoroscopy: _____

Area(s): _____

EMG/NCV: _____

Root level/nerve(s): _____

SEP: _____

Root level/nerve(s): _____

Other electrodiagnostic test(s): _____

Ultrasound: _____

Area(s): _____

Action Taken on this visit:

Exam/TX: _____

Place on disability: _____

Work restriction: _____

Referral: _____

Brace/collar: _____

Home traction device: _____

NEXERCICER: _____

Supplements: _____

Other: _____

Patient's Signature: _____ Date: _____