Authentic Chinese Acupuncture, PLLC

AUTO INJURY HISTORY FORM

Patient Name (F/L): _____ **Today's Date**: _____

Date of Birth: _____ **Gender** (M/F) ____, **Age**: _____

Date of Accident (DD/MM/YYYY): _____, AM __, PM __, **Place**: _____

Your were: Driver ( ), Passenger ( ) At: Front ( ), Back ( ), Right ( ), Left ( )	Number of people in the car: _____ Seat belt on: Yes ( ), No ( ) Type of vehicle you were in: Make model: _____ __, Year: _____
Direction you were heading: North ( ), South ( ), East ( ), West ( ) Street name: _____	Direction of other car(s): North ( ), South ( ), East ( ), West ( ) Street name: _____
Your car hit other(s)? Yes ( ), No ( ) To: Front ( ), Back ( ), Right ( ), Left ( )	Other car(s) hit yours? Yes ( ), No ( ) To: Front ( ), Back ( ), Right ( ), Left ( )
You were: Stopping ( ), Going slow ( ), Starting ( ), Moving ( )	Approximate speed of the cars: Your car: _____mph The other car(s): _____mph
Upon impact, your body was thrown: Backward ( ), Forward ( ), About ( ) Did you feel any pain right after the accident? Yes ( ), No ( ) If yes, where? _____	Any part of your body hit the car's interior? Yes ( ). No ( ) If yes, which part(s)? _____ To what part(s) of your car? _____ Cut (s) / bruise(s)? _____

You were:

Nervous ( ), Scared ( ), Panic – Stricken ( ), Shaken ( ), In shock ( ), Tense ( ), Dizzy ( ),

Confused ( ), Unconscious? Yes ( ), No ( ); if yes, for how long? _____

Police Notified? Yes ( ), No ( ); if yes, from what city? _____

Please describe the accident in your words:

_____

_____

_____

_____

_____

_____

You were hospitalized? Yes ( ), No ( ); if yes, name of hospital: _____

Type of treatment received of so far: _____

Name of attending physician(s): _____

If X – rays, where taken, list areas, result of X-ray / CT:

_____

_____

X_____ **X**_____

Patient's Signature **Date Signed**

DO NOT WRITE BELOW THIS LINE

Chief complaint/history of present illness (Location, Quality, Severity, Duration, Timing, Context, modifying Factors, Assoc Sn/Sx):

CLINICIAN USE ONLY

Discussion/Plan: