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CAD Injury History Form

General information:

Patient' name: ______________________
Today's date: ______________________
Date of injury: ______________________
Marrital status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day _____Years _____
Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy
Employment:
At time of crash: ______________________
☐ Unemployed
Currently: ______________________
☐ Unemplyed
Due to crash? ☐ Yes ☐ No
Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Past medical history:

Surgeries (dates and residuals): ______________________

Fractures (dates and residuals): ______________________

Serious illness (dates and residuals): ______________________

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

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

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

Past medical history (cont'd)

Any prior HX of current complaints:
1. ______________________
2. ______________________
3. ______________________

Prior TX by DC for these:
1. ______________________
2. ______________________
3. ______________________

Current Medical history:

Current health problems: ☐ None

Current medications taken: ☐ None

Injury history. General:

Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other _______
Vehicle driven by: ______________________
Your vehicle (year, make, model): ______________________
Your estimated speed at moment of crash: _______
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model): ______________________
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _______
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know
Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean
Other ______________________
Head position: ☐ Forward ☐ Left ___°
☐ Right ___° ☐ Up ___° ☐ Down ___°

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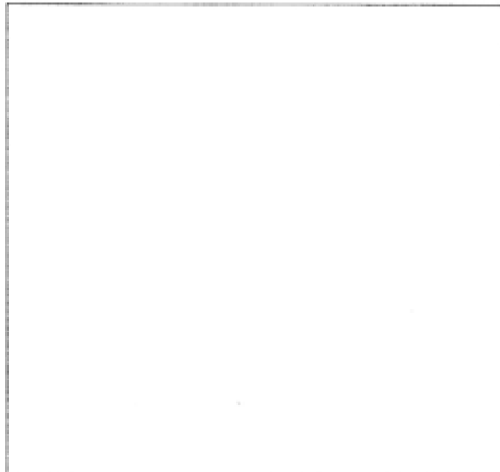
Injury history. General: (cont'd)

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?
If yes, describe____________________
Wearing hat or glasses? ☐ Yes ☐ No
If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
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-sceene? ☐ Yes ☐ No
If yes, was a report made? ☐Yes ☐No

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? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe:____________________
Special tests:____________________
Referred to:____________________
Did TX help? ☐ Yes ☐ No
Notes: ____________________
____

2. Dr.: ____________________
Specialty:__________ Date first seen:__________
Referred by:__________ TX type:__________
TX frequency:__________ TX duration:__________
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe:____________________
Special tests:____________________
Referred to:____________________
Did TX help? ☐ Yes ☐ No
Notes: ____________________
____