MANTONYA
CHIROPRACTIC CENTER LLC

Automobile Accident information

We have extensive experience in evaluating and helping patients recover from auto accidents. Please fill everything out in the next few pages. This will give us the best opportunity to document your accident and help you get better as quickly as possible.

Name: _____ Today's Date: _____

Please explain in detail how your accident happened: _____

_____

_____

Time & Date of your auto accident: _____ Were the police notified? ___Yes ___No

Was anyone else in your vehicle? ___Yes ___No If yes, who?_____

Your Auto Insurance Co: _____ Policy # _____ Claim # _____

Driver of the other vehicle (if another vehicle was involved):
Name: _____ Insurance Co: _____ Policy #_____

Driver of vehicle in which you were injured (if you were not driving):
Name: _____ Insurance Co._____ Policy #_____

Name of your insurance adjustor: _____

Have you retained an attorney? ___Yes ___No If yes, their name: _____

Their address: _____

Did you see any other doctor after your accident? ___Yes ___No If yes, what is the doctor's name?_____

What was the diagnosis? _____

What treatment(s) was given?
_____

How often did you see the doctor? _____ Are you still seeing them? ___Yes ___No

Before the accident, were you able to work on an equal basis with others your age? ___Yes ___No

Are your work activities restricted as a result of this accident? ___Yes ___No

Have you missed work due to this condition? ___Yes ___No If yes, when? _____

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905 N. 21st Street Ste. D
Newark, Ohio 43055
740-366-6601

Hebron Office
149 N. High Street
Hebron, Ohio 43025
740-928-7686

Automobile Accident Description

General Information

Your location in the vehicle: ___Driver ___Passenger
Passenger: ___Front ___Middle ___Rear
Position: ___Left ___Middle ___Right

Your Vehicle Type: ___Car ___Van ___Pick-up ___Truck
___Bus ___SUV ___Motorcycle ___Other:_____

Vehicle Size: ___Mini ___Sub-compact ___Compact
___Mid-size ___Full-size

Action: ___Stopped ___Slowing ___Accelerating Your Speed: _____

Time: ___Daylight ___Dawn ___Dusk ___Dark

Road condition: ___Dry ___Damp ___Wet ___Snowy ___Icy

Visibility: ___Good ___Fair ___Poor

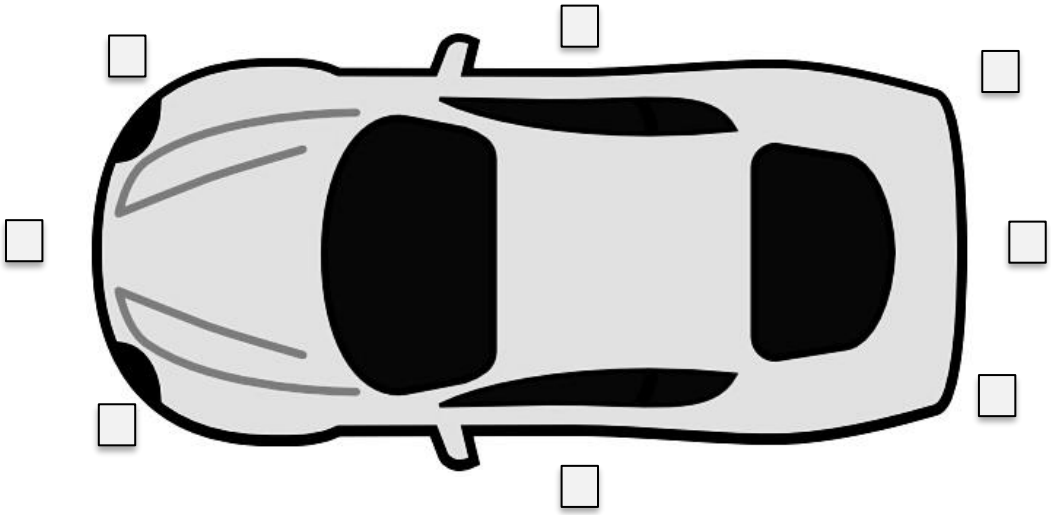
Impact Information

Impact with: ___Another Vehicle ___Object (if so, describe the object): _____

Other Vehicle Type: ___Car ___Van ___Pick-up ___Truck
___Bus ___SUV ___Motorcycle ___Other:_____

Other Vehicle Size: ___Mini ___Sub-compact ___Compact
___Mid-size ___Full-size

Impact location on your vehicle: Put an **X** in the box where your vehicle was impacted.



If there was more than one impact, please put a ***2*** *,* ***3*** *etc. in the box where your vehicle was impacted each time where appropriate.*

Damage to your vehicle: ___Minimal ___Moderate ___Extensive ___Totaled ___Unsure
Damage to the other vehicle: ___Minimal ___Moderate ___Extensive ___Totaled ___Unsure

During Impact

Seat belt: ___Yes ___No
Airbag Deployed: ___Yes ___No
Head-rest: ___Low ___Mid ___High ___None
Seat back position change: ___Yes ___No
Brakes Applied: ___Yes ___No
Seat broken: ___Yes ___No
Prepared for accident: ___Unexpected ___Expected ___Expected & Braced
Body position: ___Straight ___Rotated Left ___Rotated Right ___Unsure ___Other
Body thrown from seat: ___Yes ___No
If yes, which direction: ___Backward ___Forward ___Outside ___Unsure ___Other
Head position: ___Straight ___Rotated left ___Rotated right ___Forward ___Backward ___Unsure
Head motion: ___Forward/Backward ___Backward/Forward ___Right/Left ___Left/Right ___Unsure ___Other
Body impact *(Indicate if you experienced any pain immediately after the accident)***:**

___Head
___Left Shoulder
___Left Arm
___Left Elbow
___Left Hand
___Upper Front Torso
___Upper Back
___Left Leg
___Right Leg
___Right Shoulder
___Right Arm
___Right Elbow
___Right Hand
___Mid-Torso
___Mid-Back
___Right Knee
___Left Knee
___Lower Front Torso
___Lower Back
___Right Foot
___Left Foot
___Other:_____

After Accident

Immediately After Accident: ___Dazed/Dizzy ___Upset ___Weak ___Nervous
___Headaches ___Disoriented ___Unconscious ___Other: _____

Pain:

___Head
___Neck
___Left Hand
___Right Arm
___Upper Front Torso
___Upper Back
___Left Leg
___Left Foot
___Left Shoulder
___Right Hand
___Left Elbow
___Mid-Torso
___Mid-Back
___Right Leg
___Right Foot
___Right Shoulder
___Left Arm
___Right Elbow
___Lower Front Torso
___Lower Back
___Left Knee
___Right Knee

Numbness: ___Left Hand ___Right Hand ___Left Leg ___Right Leg
___Left Upper Arm ___Right Upper Arm ___Left Foot ___Right Foot

Medical Information (*Did you get medical care for this accident before coming into our office?)*
Medical Care: ___Yes ___No **If yes...**
Time of care: ___Next Day ___At time of accident ___Later that day ___Days later(specify)_____
Transported: ___Drove Self ___Ambulance ___Other: _____
Went to: ___Orthopedic ___Chiropractor ___Neurologist ___Family Doc ___ER
Admitted to Hospital? ___Yes ___No **If yes, how many days in hospital:**_____
Tests: ___X-rays ___Lab work ___MRI ___CT scan ___Other: _____
Treatment: ___Ice Packs ___Hot Packs Cervical Collar ___Medication ___None ___Other: _____

Previous Injuries

Have you had any previous accidents: ___Yes ___No If yes, please describe:_____

Do you have leftover pain from previous accidents: ___Yes ___No If yes, please describe:_____

Later Symptoms

Please note any symptoms that have started after the accident occurred.

Head:

___Headache ___Loss of Memory ___Light Headedness
___Fainting ___Blurred Vision ___Double Vision
___Dizziness ___Pain in ear ___Loss of Vision
Other Specify:_____

Neck:

___Pain in Neck
___Muscle Spasms
___Popping in Neck
___Other Specify:_____

Neck Pain with Movement

___Forward ___Backward ___Turn Left
___Turn Right ___Bend Left ___bend Right

Shoulders:

___Pain in Shoulder joint
___Pain across shoulder
___Tension in shoulders
___Muscle spasms in shoulder
___Other Specify:_____

Can't raise arms

___Above shoulder level
___Over head

Mid Back:

___Sharp stabbing ___Mid pain back ___Pain from front to back
___Dull Ache ___Muscle Spasms ___Pain between blades
___Pain in Kidney Area
Other Specify:_____

Lower Back:

___Low Back Pain ___Muscle Spasms

Low back pain is worse when:
___Working ___Lifting ___Stooping ___Standing
___Sitting ___Bending ___Coughing ___Lying down
Other Specify:_____

Hips, Legs & Feet:

___Pain in buttocks ___Pain and needles in Legs ___Pain down leg
___Pain in hip joint ___Feet feeling cold ___Swollen feet
___Numbness in toes ___Numbness of leg ___Knee pain
___Leg cramps ___Cramps in feet
Other Specify:_____

Arms & Hands:

___Pain in fingers ___Numbness in Left Arm
___Pin & needles in hands ___Numbness in Right Arm
___Pin & needles in fingers ___Cold hands
___Swollen joints in fingers ___Loss of grip strength
Other Specify:

Chest:

___Chest pain ___Pain around ribs ___Shortness of Breath ___Breast Pain
Other Specify:_____

Abdomen:

___Nervous Stomach ___Nausea ___Diarrhea ___Gas ___Constipation
Other Specify:_____

General:

___Nervousness ___Fatigue
___Irritable ___Depressed
___Generally feel run down ___Prostate pain/swelling
___Difficulty urinating ___Night urination problems
___Cramping ___Irregularity

___Loss of Sleep: _____ hours per night

___Loss of weight: _____ lbs.

___Gain of weight: _____ lbs.

Other:_____

Signature: _____ Date:_____