



Kruse – Manley Clinic of Chiropractic  
4716 Morningside Ave. ~ Sioux City, IA 51106

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Auto Related Accident

Date & Time of Accident: \_\_\_\_\_  a.m.  p.m.

Were you the:  Driver  Front Passenger  Rear Passenger Ticket Issued?  Self  Other  None

Number of people in your vehicle? \_\_\_\_\_ Did the police come to the accident site?  Yes  No

Was a police report filed?  Yes  No Were you wearing your seatbelt at the time of the accident?  Yes  No

Were there any witnesses?  Yes  No What did your vehicle impact?  Another vehicle  Other \_\_\_\_\_

Was the vehicle equipped with airbags?  Yes  No If Yes, did they inflate?  Yes  No

In relation to the base of your skull, where was the headrest?  Above  Below  At the base of the skull

Did any part of your body strike anything in the vehicle?  Yes  No If yes, explain: \_\_\_\_\_

Make and Model of the vehicle you were occupying? \_\_\_\_\_

Name and location/street on which you were traveling? \_\_\_\_\_

In which direction were you headed?  North  South  East  West Approx. Speed of your vehicle? \_\_\_\_\_

Where did the impact to your vehicle occur?  Front  Rear  Right Side  Left Side  Other

Make and Model of the other vehicle? \_\_\_\_\_

In which direction was the other vehicle headed?  N  S  E  W Approx. Speed of other vehicle? \_\_\_\_\_

Please describe the accident in your own words: \_\_\_\_\_

## Work Related Accident

Date & Time of Accident: \_\_\_\_\_  a.m.  p.m.

Briefly describe the accident in your own words: \_\_\_\_\_

Where did the accident occur (include address)? \_\_\_\_\_

Was anyone else present during your accident?  Yes  No Did you properly report the accident?  Yes  No

What recommendations were made by your employer after reporting? \_\_\_\_\_

Has this type of accident happened before?  Yes  No Has this happened in your workplace before?  Yes  No

## After Injury

Did the accident render you unconscious?  Yes  No If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_

Have you gone to the Hospital or seen any other doctors for these injuries?  Yes  No

If yes, when did you go?  Just after accident  Next day  2 days or more By?  Ambulance  Private transport

Name of hospital and/or Attending Doctor: \_\_\_\_\_

Describe any treatment you received: \_\_\_\_\_

Were x-rays taken?  Yes  No

Have you been able to work since this injury?  Yes  No

Was medication prescribed?  Yes  No

Has your work been restricted since this injury?  Yes  No

Is your condition getting worse?  Yes  No

How often does it occur?  Constant  Comes and Goes

Please check all of the symptoms that are a result of this accident:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Jaw Problems      | <input type="checkbox"/> Nausea          |
| <input type="checkbox"/> Memory Loss    | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Back Pain       |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Numb Hands/Fingers  | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Tension           | <input type="checkbox"/> Back Stiffness  |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Leg Pain        |
| <input type="checkbox"/> Ears Ringing   | <input type="checkbox"/> Stomach Upset       | <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Numb Feet/Toes  |
| <input type="checkbox"/> Other _____    |  |  |  |

Please check all of the activities that are painful or uncomfortable to perform (even if only sometimes):

- |  |   |  |                                     |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Lying on Back | <input type="checkbox"/> Lying on Stomach | <input type="checkbox"/> Lying on Side | <input type="checkbox"/> Sitting    |
| <input type="checkbox"/> Standing      | <input type="checkbox"/> Standing         | <input type="checkbox"/> Stretching    | <input type="checkbox"/> Lovemaking |
| <input type="checkbox"/> Walking       | <input type="checkbox"/> Running          | <input type="checkbox"/> Sports        | <input type="checkbox"/> Working    |
| <input type="checkbox"/> Lifting       | <input type="checkbox"/> Bending          | <input type="checkbox"/> Kneeling      | <input type="checkbox"/> Reaching   |

Have you retained an attorney?  Yes  No If yes, whom? \_\_\_\_\_

## Recovery

To evaluate the effect that continuing work will have on your recovery phase, please complete the following:

How many hours are in a normal work day? \_\_\_\_\_ Is light duty work available to you?  Yes  No

Please check any of the following activities you asked to perform for your job (even if occasionally):

- |                                   |                                  |  |                                   |
|-----------------------------------|----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Operating Equipment       | <input type="checkbox"/> Sitting  |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Walking | <input type="checkbox"/> Work with arms above head | <input type="checkbox"/> Crawling |
| <input type="checkbox"/> Typing   | <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending                   | <input type="checkbox"/> Stooping |

If any of your medical or account information has changed, please inform our front desk personnel.

**\*\*I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.\*\***

Signature \_\_\_\_\_ Date \_\_\_\_\_