YUCHA
MEDICAL PAIN MANAGEMENT & CHIROPRACTIC REHABILITATION

Randy E. Yucha, DC
Mary Kashurba, MD
Rod Gabel, DC
Tony Odell, DC
Lucas Rizzardi, DPT
Shannon McCormick,PA-C

VEHICLE ACCIDENT/PERSONAL INJURY INFORMATION

PATIENT/CLAIM INFORMATION

Date _____ Insurance Carrier_____ Case/Claim #: _____

Patient Name _____ Attorney Name/Phone #: _____

Date of Accident _____ Time of Accident _____ ☐ am ☐ pm

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest Intersection with road/street _____

Driving conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other_____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE (if applicable)

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was the vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Mid-position ☐ High

OTHER VEHICLE (if applicable)

Make and model of other vehicle _____

What direction was other vehicle traveling? _____

Speed other vehicle was traveling _____

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No

If yes, explain _____

_____

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other _____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which hand was on the wheel? ☐ Right ☐ Left

Were you? ☐ Surprised by impact ☐ Braced for impact

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? _____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after the accident ☐ Next day ☐ 2 days or more after the accident

Name of the hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken or other imaging/studies done: ☐ Yes ☐ No If testing in addition to, or instead of x-rays, please list

_____

Location(s)/Facility? _____

SYMPTOMS / INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed? _____

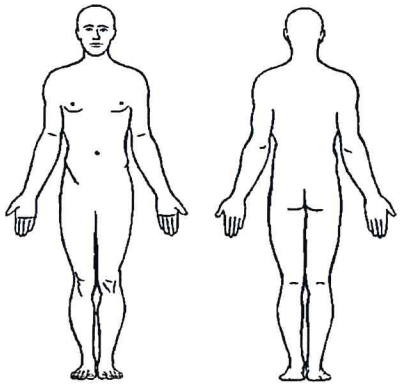
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Ear ringing	☐ Jaw problems	☐ Shortness of breath
☐ Back pain	☐ Fatigue	☐ Leg pain	☐ Sleep difficulty
☐ Back stiffness	☐ Feet/toe numbness	☐ Memory loss	☐ Stomach upset
☐ Chest pain	☐ Hand/finger numbness	☐ Nausea	☐ Tension
☐ Dizziness	☐ Headaches	☐ Neck pain	☐ Vision blurred
☐ Ear buzzing	☐ Irritability	☐ Neck stiff	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling
Shooting ☐ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

_____ _____

Patient Signature Date