Sarasota Chiropractic, Physical Therapy & Massage

Sensitive, Compassionate, Professional, Thoughtful and More

Abraham Kozma, D.C., P.A./ Patricia Vulopas, MSPT
2801 Fruitville Rd. Suite 180 * Sarasota * Florida * 34237-5357
Office 941-924-9892 ** Fax 941-924-7283

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR OUR RECORDS

Name: _____

Do you smoke cigarettes, cigars, pipe or chew tobacco? Y N How much per day? _____

Do you drink alcoholic beverages? Y N How many per week? _____

Do you exercise daily? Y N What areas of your body? _____
_____

Name of your medical doctor/ primary care doctor?_____

Have you been treated for any health condition other than this accident in the past year?
If yes, please explain_____
_____
_____

List any operation you have had for any reason: _____
_____
_____
_____
_____

Have you been treated by a **chiropractor/physical therapy** for any reason prior to this accident?_____
_____

Have you had **any previous** automobile accidents? Y N If yes, when and were any injuries sustained, who treated you and for how long?_____
_____
_____
_____

Have you been diagnosed with any of the following: (Please circle any appropriate answers)?

Alcoholism Anemia Arthritis Cancer Depression Diabetes Eczema

Epilepsy Hear Disease Mental disorder Sexually Transmitted disease

Patient's Signature _____ Date: _____

AUTOMOBILE ACCIDENT HISTORY FORM
PLEASE FILL OUT ALL QUESTIONS TO THE BEST FO YOUR ABILITY
PLEASE PRINT ALL ANSWERS, INITIAL, and SIGN EACH FORM AT THE BOTTOM

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ AM/PM

City of Accident: _____ Street of Accident: _____

Please describe to the best of your knowledge, what happened during this accident: _____

Did the police come to the accident scene? Y N Is there a report on file? Y N

Did you go to the hospital Y N If yes, which hospital? _____

How did you get there? _____ Were x-rays or scans done Y N If yes, which areas of the body? _____

What did the hospital do for your injuries? _____

How long did you stay in the hospital? _____

What bleeding cuts did you sustain during the accident? _____

What bruises did you sustain during the accident? _____

Did you receive any injury or bruises **from the seat belt**? Y N If yes, please describe: _____

On what part of the vehicle did your following body parts hit?

a. head hit _____ b. chest hit _____
c. right/ left shoulder hit _____ d. right/left arm hit _____
e. right/left hip hit _____ f. right/left leg hit _____
g. right/left knee hit _____ h. other _____

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?
AWARE SURPRISED

Did you lose consciousness (black out) upon impact? Y N; How long? _____

Did you experience a flash of light or explosion in your head? Y N

Please Initial here _____

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AUTOMOBILE ACCIDENT HISTORY FORM

Check **all** the symptoms you have noticed since the accident:

Headache	neck pain	neck stiffness	sleeping problems
Shoulder pain	arm pain	mid back pain	low back pain
Nervousness	tension	irritability	chest pain
Dizziness	arms tingle	legs tingle	hands numb
Feet numb	shortness/breath	fatigue	depression
Ears ringing	fainting	anxiety	panic attacks
Jaw pain	memory loss	loss of taste	loss of smell
Diarrhea	face flushed	cold hands	cold feet
Fever	stomach upset	cold seats	flu-like symptoms
Constipation	loss of balance	pain after meals	leg pain
Nausea	restlessness	forgetful	difficulty concentrating
Reduced tolerance to heat		reduced tolerance to alcohol	
Lightheaded	blurred vision	confusion	disoriented

Other (describe) _____

_____

Just prior to the accident in question, did you have any of the above symptoms? If so, please write here which symptoms you had: _____

_____

_____

_____

Please describe how you felt:

A. During the accident _____

B. Immediately after the accident: _____

C. The following day: _____

Since the accident have your symptoms become: a. better b. worse c. same

Do you notice any restrictions in your activity as a result of this injury? _____

_____

_____

Patient's Initials: _____

AUTOMOBILE ACCIDENT HISTORY FORM

Have you retained an attorney? Y N If yes, who: _____

Have you contacted your Insurance Company? Y N

Were there any witnesses? Y N (names) _____

Have you been treated by another doctor since the accident? Y N, If yes, who? _____

What type of treatment did you receive? A. chiropractic b. medical c. massage d. physical therapy e. psychological counseling f. exercise g. other _____

Have you lost time from work due to this injury? Y N If yes, please complete the type of employment _____ last day worked _____

Are you being compensated for the time lost from work? Y N If yes, what type of compensation?

_____

Number of people in your automobile: _____

What direction were you headed in N S E W on (name of street)_____

Were you struck from: a. behind b. front c. left side d.. right side OR did you strike the other vehicle with you're: a. front end b. rear end

Give the year, make, and model of the vehicle **you** were in: Year _____ Make _____ Model _____

What is the estimated cost of damage to the vehicle you were in? $_____

What was the year, make, and model of the **other** vehicle? Year _____ Make _____ Model _____

Road conditions at the time of the accident: WET DRY ICY OTHER _____

Was your car stopped at the time of the impact? YES NO

Patient's Initials_____

AUTOMOBILE ACCIDENT HISTORY FORM

If yes your car was stopped at the time of impact, was the driver's foot also on the brake? YES NO

If NO, then estimate the speed of the vehicle YOU were in: _____mph

If YOUR vehicle was moving at the time of the impact, was it:

a. slowing down b. gaining speed c. traveling at a steady rate

Was the OTHER vehicle MOVING at the time of the collision? YES NO

If the other vehicle was moving at the time of the collision, was it:

a. slowing down b. gaining speed c. traveling at a steady rate

Which of the following car parts broke during the accident?

a. windshield b. front / back seat c. steering wheel d. right/left window
e. other _____

WHERE were, you seated in the vehicle? _____

Was the trunk of your body pointed straight forward at the time of the collision? Y N If no, how was it turned? _____

Was your head pointed straight forward? Y N If no, what direction was it turned and by how much?

How far is the top of the head restraint or seatback from the top of your head? (approximately) _____
ABOVE HEAD? BELOW HEAD?

Were you wearing a shoulder-lap seat belt? Y N Not Applicable

Presently working Y N full time part time off work due to injury? Y N

If off work, for how long? _____

What are your chief complaints TODAY from the accident?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient's Signature: _____ **Date:** _____