Accident History and Examination Form

Name: Date: / /

ACCIDENT DESCRIPTION

Date of accident / / Was it work related? Y N Was it an auto accident? Y N

Other? ______________________________

Please describe what happened.

Were you treated by anyone else? Y N By whom? ______________ When? ________

Please explain.

Were you disabled (unable to work)? Y N From ____________ To ____________
Date Date

Any broken bones, bruises, or abrasions? Y N If so, where? ______________________

Were you wearing your seatbelt? Y N Did you hit your head? Y N Where?__________

SYMPTOMS

Since the accident, have you experienced any of the following symptoms?
How frequently *(O=occasionally, F=frequently, C=constantly)*?

PAIN OR NUMBNESS in:

❑ Neck	O	F	C	❑ Right Hip	O	F	C
❑ Right Arm	O	F	C	❑ Left Hip	O	F	C
❑ Left Arm	O	F	C	❑ Right Leg	O	F	C
❑ Right Shoulder	O	F	C	❑ Left Leg	O	F	C
❑ Left Shoulder	O	F	C	❑ Right Knee	O	F	C
❑ Right Wrist	O	F	C	❑ Left Knee	O	F	C
❑ Left Wrist	O	F	C	❑ Right Foot	O	F	C
❑ Mid Back	O	F	C	❑ Left Foot	O	F	C
❑ Lower Back	O	F	C				

❑ Other: ______________________________ O F C

NEUROLOGICAL SYMPTOMS

❑ Ringing in Ears	O	F	C
❑ Fainting	O	F	C
❑ Dizziness	O	F	C
❑ Nausea	O	F	C
❑ Blurred Vision	O	F	C
❑ Headache	O	F	C
❑ Digestive Trouble	O	F	C
❑ Loss of Sleep	O	F	C
❑ Asthma	O	F	C

RELEASE of INFORMATION (for insurance)

I hereby authorize and direct Timothy Knight, D.C. to release all information necessary to process this claim.

____
Signature

I hereby authorize and direct my insurance carrier to pay all benefits which may be due me according to my policy directly to Timothy Knight, D.C. to be applied to my account.

____
Signature

KNIGHT CHIROPRACTIC
HEALTH CARE FOR CHILDREN AND ADULTS

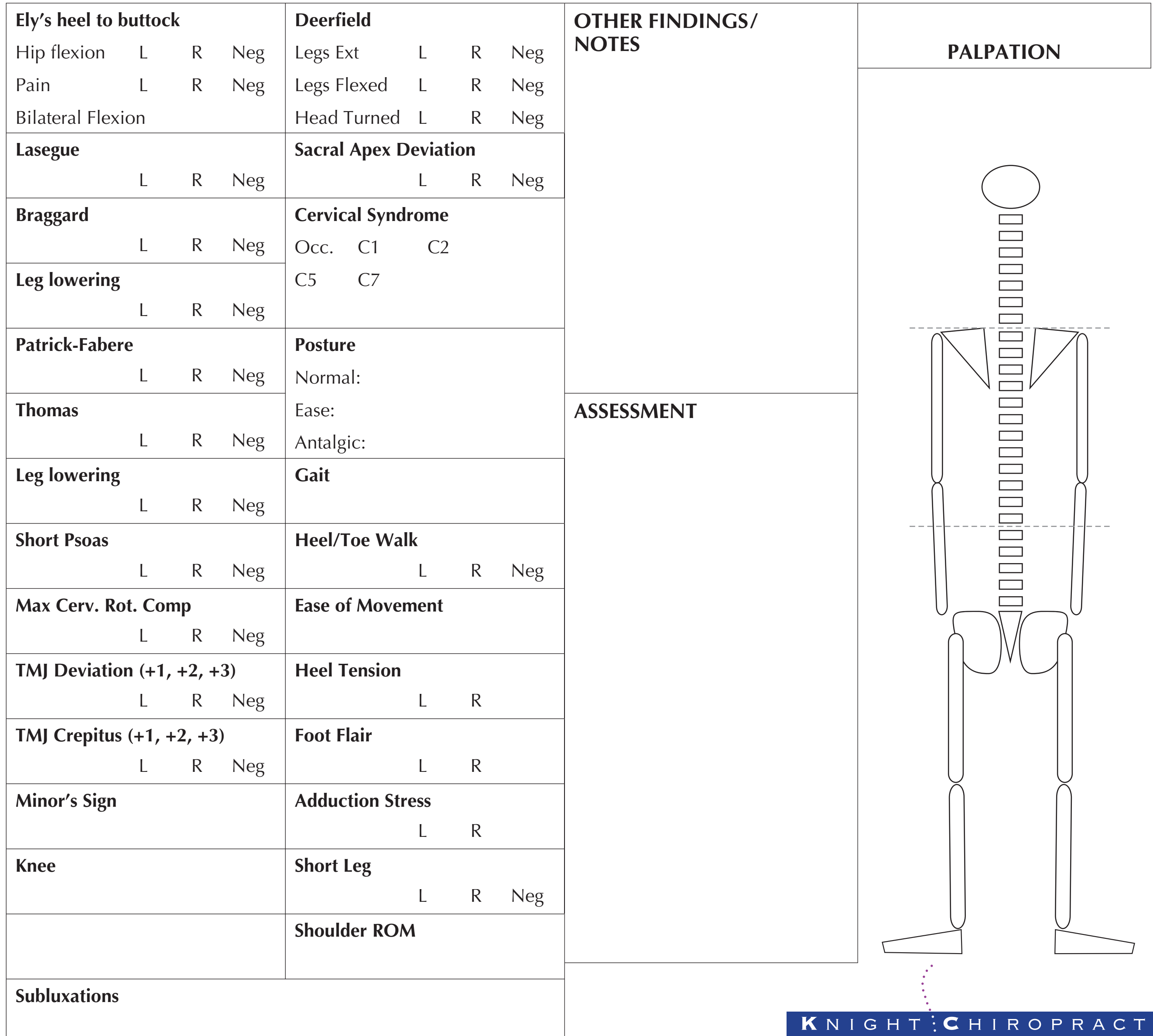
Thoraco-Lumbar ROM

	EXAM	PAIN* (1-4)	SHARP/ DULL	LOCATION OF PAIN
Flexion				
Extension				
Rt. Lateral				
Lt. Lateral				
Rt. Rotation				
Lt. Rotation				

Cervical ROM

	EXAM	PAIN* (1-4)	SHARP/ DULL	LOCATION OF PAIN
Flexion				
Extension				
Rt. Lateral				
Lt. Lateral				
Rt. Rotation				
Lt. Rotation				

**1=mild, 2=moderate, 3=moderately severe, 4=very severe*



Ely's heel to buttock Hip flexion L R Neg Pain L R Neg Bilateral Flexion	**Deerfield** Legs Ext L R Neg Legs Flexed L R Neg Head Turned L R Neg
Lasegue L R Neg	**Sacral Apex Deviation** L R Neg
Braggard L R Neg	**Cervical Syndrome** Occ. C1 C2 C5 C7
Leg lowering L R Neg	
Patrick-Fabere L R Neg	**Posture** Normal: Ease: Antalgic:
Thomas L R Neg	
Leg lowering L R Neg	**Gait**
Short Psoas L R Neg	**Heel/Toe Walk** L R Neg
Max Cerv. Rot. Comp L R Neg	**Ease of Movement**
TMJ Deviation (+1, +2, +3) L R Neg	**Heel Tension** L R
TMJ Crepitus (+1, +2, +3) L R Neg	**Foot Flair** L R
Minor's Sign	**Adduction Stress** L R
Knee	**Short Leg** L R Neg
	Shoulder ROM
Subluxations	

OTHER FINDINGS/ NOTES

ASSESSMENT

PALPATION

KNIGHT CHIROPRACTIC
ARLINGTON, MA (781) 641-2510