

Mareechi Duvvuri, DC
2953 SE Turner Creek Dr.,
Hillsboro, OR 97123

AUTO ACCIDENT HISTORY FORM

Name: _____ Date: _____

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

Describe accident in your own words: _____

You were: _____ Driver _____ Passenger _____ Passenger position: _____ front; _____ right rear; _____ left rear; _____ middle _____

The impact was from _____ front; _____ right side; _____ left side; rear. At impact you were facing _____ forward; _____ right _____ left.

At impact were your hands on steering wheel? _____ yes; _____ no. At impact was your foot on the brake? _____ yes; _____ no.

Were you wearing a seatbelt? _____ yes; _____ no. If you have an airbag in your car, did it inflate on impact? _____ yes; _____ no.

Were you braced for impact? _____ yes; _____ no. Were you: _____ aware of, or surprised by the impact?

Did you strike anything in the car at impact? _____ no; _____ yes, if yes please describe: _____

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

Was your car stopped at time of impact? _____ yes; _____ no. If no, estimate what speed you were traveling: _____ MPH.

Did you receive injury or bruise from the seatbelt? _____ yes; _____ no; If yes, describe: _____

Did police respond to the accident? _____ yes; _____ no. Were you issued a citation? _____ yes; _____ no.

At or following the impact did you experience a flash of light or a feeling of explosion in your head? _____ yes; _____ no; _____ NA

Did you lose consciousness? _____ yes; _____ no. If yes, for how long? _____

Immediately following the impact, did you experience: _____ dizziness; _____ confusion; _____ nausea; _____ ringing in ears;
_____ blurred vision; _____ light headedness; _____ feeling disoriented.

List any of the above symptoms you are still experiencing: _____

Did you go to a hospital/emergency center? _____ yes; _____ no; If yes, where: _____ when: _____

How did you get to the hospital? _____ Name of attending doctor: _____

Doctor's recommendations, if any: _____

Any previous auto accidents? _____ yes; _____ no; If yes, describe: _____

Have you lost any time from work because of this accident? _____ yes; _____ no; Date: from _____ to _____

Occupation: _____ Any duties affected by these injuries? _____

Patient Signature: _____ Date: _____

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CHECK ANY SYMPTOMS YOU HAVE NOTICED SINCE THIS ACCIDENT:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Pins/needles in arm |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Pins/needles in leg |
| <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Ankle pain | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Low-back pain | <input type="checkbox"/> Foot pain | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Arm pain | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Jaw Clicking | <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Wrist pain | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Hand pain | <input type="checkbox"/> Heavy head |
| <input type="checkbox"/> Intolerance to cold | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Upset stomach |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Uncoordinated |

Personal Injury Protection (PIP) Insurance Information

Your auto insurance company:

Claim address:

Claim number for this accident: _____

Is your PIP application completed? Yes No Date: _____

Do you have an attorney advising you in this accident? Yes No

Attorney's name: _____ Phone #: _____

Patient's signature _____ Date _____

