



# PATIENT HISTORY OF COLLISION

Intake procedure for patients with motor vehicle crash history – Ver 1.3

**Canyon Creek Chiropractic**  
**Dr. Malka Carlucci**  
7109 S Highland Dr  
Suite-203  
Cottonwood Heights, UT 84121  
801-943-0932

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient Number (office use only)

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Claim Alphanumeric

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Policy Holder (if different from patient)

\_\_\_\_\_  
Adjuster Name

\_\_\_\_\_  
Adjuster Phone

\_\_\_\_\_  
Adjuster Fax

\_\_\_\_\_  
Adjuster E-mail

\_\_\_\_\_  
Name of Lawyer / Firm

\_\_\_\_\_  
Lawyer Phone

\_\_\_\_\_  
Lawyer Fax

\_\_\_\_\_  
Lawyer E-mail

\_\_\_\_\_  
Accident Address or Approximate Location

\_\_\_\_\_  
State

\_\_\_\_\_  
Accident Date

\_\_\_\_\_  
# of Cars Involved

\_\_\_\_\_  
Was this accident work related?  
 Yes  No

### Accident Details:

Briefly describe by text/Picture

### Vehicle Type

Car    S.U.V.    Van    Bus    Large truck    Pick-up    Other

\_\_\_\_\_  
Your Vehicle Build / Year

\_\_\_\_\_  
Other's Vehicle Build /Year

### Your position at time of Accident

Driver    Front Passenger    Left Rear Passenger    Right Rear Passenger

\_\_\_\_\_  
Time of Accident

\_\_\_\_\_  
Your Vehicle Speed

\_\_\_\_\_  
Their Vehicle Speed

### Damage to your Vehicle

Mild    Moderate    Totaled

### Your Vehicle Transmission

Automatic    Manual

Does or did your vehicle have automatic cruise control?    Yes    No

Was cruise control active?    Yes    No

### What was your vehicle doing at the time of the accident?

Stopped at an intersection    Stopped in traffic    Stopped at light  
 Making a right turn    Making a left turn    Parking  
 Proceeding along    Slowing down    Accelerating

### Were others injured?

Yes    No   How many others? \_\_\_\_\_

### Visibility at Time of Accident

Good    Fair    Poor

### Road Conditions at Time of Accident

Icy    Wet    Sandy    Dark    Clean and Dry

### Point of Impact

Head-On    Rear-End  
 Left front    Right front  
 Left Rear    Right Rear  
 Roll-over/ Flipped-over

### Who hit who/what?

You hit other vehicle  
 Other vehicle hit you  
 You hit: \_\_\_\_\_



**Canyon Creek Chiropractic - Dr. Malka Carlucci**  
7109 S Highland Dr Suite-203  
Cottonwood Heights, UT 84121  
801-943-0932



# PATIENT HISTORY OF COLLISION

Intake procedure for patients with motor vehicle crash history – Ver 1.3

**Canyon Creek Chiropractic**  
**Dr. Malka Carlucci**  
7109 S Highland Dr  
Suite-203  
Cottonwood Heights, UT 84121  
801-943-0932

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Patient Number** (office use only)

### Body position/vehicle reaction/etc..

- Did you see the accident coming?       Yes     No
- Were you braced for the impact?         Yes     No
- Did you have a seat belt on?             Yes     No
- Did you have a shoulder harness on?     Yes     No
- Did the driver's forward air bag deploy?  Yes     No
- Did the passenger's forward bag deploy?  Yes     No
- Did the side air bags deploy?            Yes     No
- Does your vehicle have headrests?       Yes     No
- Did you receive any chemical burns?    Yes     No
- Did you receive cut/bruises/scrapes?    Yes     No
- Were you treated by the paramedics?    Yes     No

### What was the position of your headrest?

- Even with top of head                       Even with the middle of the neck
- Even with bottom of head

### What was the direction of your head at the time of impact?

- Facing straight forward                       Turned to the right
- Turned to the left

Foot position:    Brake     Gas Pedal     Clutch (oLoR)

### How were you seated (slumping, etc)?

**Did your body strike the inside of your vehicle?**       Yes     No

**Did you lose consciousness?**     Yes     No

If you answered yes, for how long? \_\_\_\_\_

**If you answered "yes" to the above, describe**

### Your vehicle's estimated damages

### Damage to their vehicle

- Mild       Moderate       Totaled

**Did police show up at the scene?**       Yes     No

**Was an accident report filled out?**                       Yes     No

**Was anyone issued a citation?**               Yes     No

\_\_\_\_\_  
**If a citation was issued, to whom was it issued?**

### Where did you go after the accident?

- Home     Work     Hospital ER     Private Doctor

### How did you get to the place to which you went after the accident?

- Drove self                       Ambulance                       Someone else
- Police

### Emergency Room / Hospital / Laboratory inquiries if applicable

\_\_\_\_\_  
**Hospital/Facility/Physician Name**

\_\_\_\_\_  
**H/F/P - Phone**

\_\_\_\_\_  
**H/F/P - Fax**

\_\_\_\_\_  
**H/F/P - E-mail**

**Did you receive X-Rays?**                       Yes     No

**Was lab work done?**                       Yes                       No

\_\_\_\_\_  
**If yes, what body parts were imaged?**

\_\_\_\_\_  
**If you answered "yes", what laboratory work was ordered?**

\_\_\_\_\_  
**What did the imaging reveal?**

\_\_\_\_\_  
**What treatments were given?**

- Cervical Collar                                       Ice
- Other : \_\_\_\_\_



**Canyon Creek Chiropractic - Dr. Malka Carlucci**  
7109 S Highland Dr Suite-203  
Cottonwood Heights, UT 84121  
801-943-0932



# PATIENT HISTORY OF COLLISION

Intake procedure for patients with motor vehicle crash history – Ver 1.3

**Canyon Creek Chiropractic**  
**Dr. Malka Carlucci**  
7109 S Highland Dr  
Suite-203  
Cottonwood Heights, UT 84121  
801-943-0932

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Patient Number** (office use only)

**Have you missed work due to the accident?**

Yes  No

**Are you functionally disabled as a result of your injuries?**

Yes  No

**If you answered "yes" to the above, how much?** \_\_\_\_\_

**If "yes", are you using household services?**  Yes  No

**Have you had any previous accidents?**  Yes  No

**Any previous hospitalizations/surgeries/broken bones?**

Yes  No

**If you answered "yes" to the above, were you injured?**  
 Yes  No

\_\_\_\_\_  
**If you answered "yes" on all the above, what was the date of the prior accidents? Provide related injuries.**

\_\_\_\_\_  
**Please provide the dates and reason if you answered "yes" to the above.**

## Symptoms – Check if Present

**When did your symptoms begin?** \_\_\_\_\_

**Any symptoms prior to the accident?**  Yes  No

### Musculoskeletal

### Circle Location

### Neurological

### Circle Location

Tension	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Both
Jaw Pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Neck Pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Neck stiffness	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Upper back pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Upper back stiffness	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Mid back pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Mid back stiffness	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Low back pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Lower back stiffness	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Rib pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Abdominal pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Shoulder pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Shoulder stiffness	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Arm pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Elbow pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Forearm pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Wrist pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Hand pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Finger pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Hip/Groin/Thigh pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Pain radiating to legs	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Knee pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Lower leg/calf/shin pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Ankle pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Toe/Foot pain	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B

Headache	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Pins & Needle in arm	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Numbness in fingers	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Pins & needle into the legs	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Toe Numbness	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	
Arithmetic problems	<input type="radio"/> Yes <input type="radio"/> No	
Concentration problems	<input type="radio"/> Yes <input type="radio"/> No	
Confusion	<input type="radio"/> Yes <input type="radio"/> No	
Depression	<input type="radio"/> Yes <input type="radio"/> No	
Dizziness	<input type="radio"/> Yes <input type="radio"/> No	
Easily distracted	<input type="radio"/> Yes <input type="radio"/> No	
Fear of travel in a car	<input type="radio"/> Yes <input type="radio"/> No	
Flashbacks	<input type="radio"/> Yes <input type="radio"/> No	
Irritability	<input type="radio"/> Yes <input type="radio"/> No	
Lightheadedness	<input type="radio"/> Yes <input type="radio"/> No	
Loss of balance	<input type="radio"/> Yes <input type="radio"/> No	
Loss of memory	<input type="radio"/> Yes <input type="radio"/> No	
Mood Swings	<input type="radio"/> Yes <input type="radio"/> No	
Nervousness	<input type="radio"/> Yes <input type="radio"/> No	
Nightmares	<input type="radio"/> Yes <input type="radio"/> No	
Outbursts of anger	<input type="radio"/> Yes <input type="radio"/> No	
Personality changes	<input type="radio"/> Yes <input type="radio"/> No	

\_\_\_\_\_  
**Notes**



**Canyon Creek Chiropractic - Dr. Malka Carlucci**  
7109 S Highland Dr Suite-203  
Cottonwood Heights, UT 84121  
801-943-0932

**PAGE**  
**3/4**

**CCC Medical Paperwork**



# PATIENT HISTORY OF COLLISION

Intake procedure for patients with motor vehicle crash history – Ver 1.3

**Canyon Creek Chiropractic**  
**Dr. Malka Carlucci**  
7109 S Highland Dr  
Suite-203  
Cottonwood Heights, UT 84121  
801-943-0932

Today's Date

Patient Number (office use only)

### Symptoms continued ...

#### Digestive

- Alcohol intolerance     Yes     No
- Constipation             Yes     No
- Diarrhea                  Yes     No
- Indigestion               Yes     No
- Loss of appetite         Yes     No
- Loss of Taste             Yes     No
- Nausea                   Yes     No
- Stomach upset          Yes     No

#### Respiratory

- Loss of Smell             Yes     No
- Shortness of breath     Yes     No

#### Endocrine

- Cold sweats             Yes     No
- Fatigue                  Yes     No

#### Cardiovascular

- Chest pain               Yes     No
- Irregular Heartbeat     Yes     No

#### Constitutional

- Apathy                  Yes     No
- Boredom                 Yes     No
- Face flushed             Yes     No
- Fainting                  Yes     No
- Fever                     Yes     No
- Sleeping problems      Yes     No
- Stress                   Yes     No
- Difficulty w/ planning  Yes     No

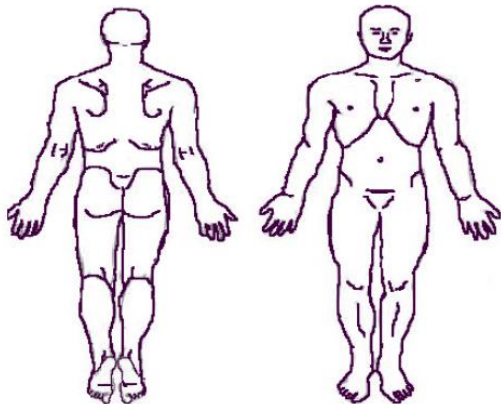
#### Sensory

- Blurring of vision       Yes     No
- Buzzing in ears         Yes     No
- Cold feet                 Yes     No
- Cold hands              Yes     No
- Pain behind the eyes    Yes     No
- Ringing in ears         Yes     No
- Sensitivity to light      Yes     No
- Sensitivity to sound     Yes     No
- Tinnitus                 Yes     No

#### Genitourinary

- Erectile Dysfunction    Yes     No
- Loss of libido            Yes     No

### Location Map (indicate by number on image)



### Symptom and Radiation

### Frequency

### Intensity (1 – 10)

### Action affecting pain

Ex: 0. Mid-back

Constant

8

Bending down

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_
- 6 \_\_\_\_\_
- 7 \_\_\_\_\_

Patient Signature (Printed)

Patient Signature

Date



**Canyon Creek Chiropractic - Dr. Malka Carlucci**  
7109 S Highland Dr Suite-203  
Cottonwood Heights, UT 84121  
801-943-0932