

# Healing Touch Chiropractic, Sports Medicine & Spine Rehabilitation

Vladimir Friedman, DC, CCN, CCSP  
Jeffrey Friedman, DC, CCN  
Robert Curran, DC

308 Neptune Avenue  
Brooklyn, NY 11235

## Auto Accident Injury Information

Patient's Name: \_\_\_\_\_

Date of accident: \_\_\_ / \_\_\_ / \_\_\_ Approximate Time: \_\_\_\_\_

Location of accident: \_\_\_\_\_

**Circumstances surrounding accident**, i.e. road conditions, actions of your vehicle and the other vehicle if applicable:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you lost any workdays as a result of this accident?** \_\_\_ No \_\_\_ Yes

**Dates of missed worked?** \_\_\_\_\_

**Type of employment?** \_\_\_\_\_

**What was your position in the vehicle?**

\_\_\_ The driver \_\_\_ The rear passenger \_\_\_ The front passenger \_\_\_ A pedestrian \_\_\_ Other: \_\_\_\_\_

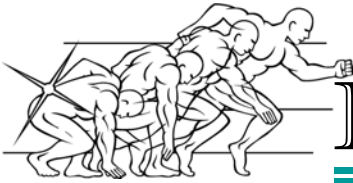
**What type of vehicle were you traveling in?**

\_\_\_ Compact car \_\_\_ Full size car \_\_\_ Full size truck \_\_\_ Full size van  
\_\_\_ Mid size car \_\_\_ Compact truck \_\_\_ Mini van \_\_\_ Compact sport utility vehicle  
\_\_\_ Full size sport utility vehicle \_\_\_ Motor Home  
\_\_\_ Motorcycle \_\_\_ Bicycle \_\_\_ Other: \_\_\_\_\_

**What speed were you traveling at the time of the accident?**

\_\_\_ Stopped at a stop light \_\_\_ At a complete stop  
\_\_\_ Slowing down at an intersection \_\_\_ Moving slowly  
\_\_\_ Traveling at approximately \_\_\_ mph \_\_\_ Merging into traffic  
\_\_\_ Turning right \_\_\_ Turning left  
\_\_\_ Traveling faster than 65 mph \_\_\_ Other: \_\_\_\_\_

**Who hit whom?**



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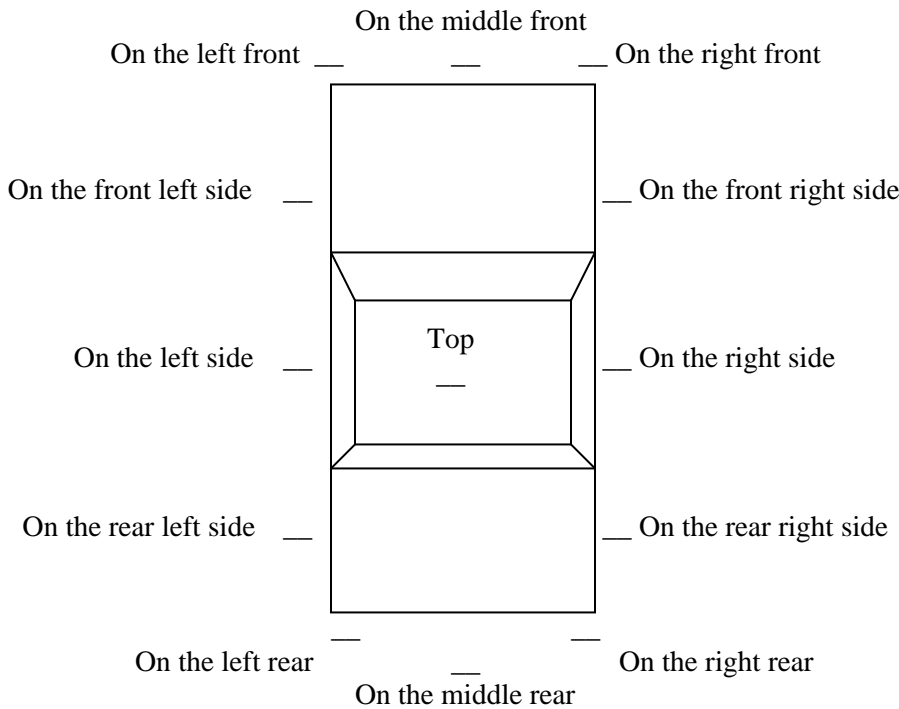
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- Was struck by another vehicle
- Struck a stationary object
- Struck another vehicle
- Other: \_\_\_\_\_

**How many passengers were in the vehicle you were traveling in beside you?** \_\_\_\_\_

**What was your vehicle's point of impact?**

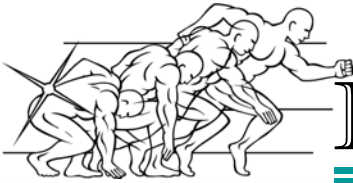


**What type of vehicle was the other driver traveling in?**

- Compact car
- Full size car
- Full size truck
- Full size van
- Mid size car
- Compact truck
- Mini van
- Compact sport utility vehicle
- Full size sport utility vehicle
- Motor Home
- Motorcycle
- Bicycle
- Other: \_\_\_\_\_

**What speed was the other vehicle traveling?**

- Stopped at a stop light
- At a complete stop
- Slowing down for an intersection
- Moving slowly
- Traveling faster than 65 mph
- Merging into traffic
- Traveling at approximately \_\_\_\_\_ mph
- Other: \_\_\_\_\_



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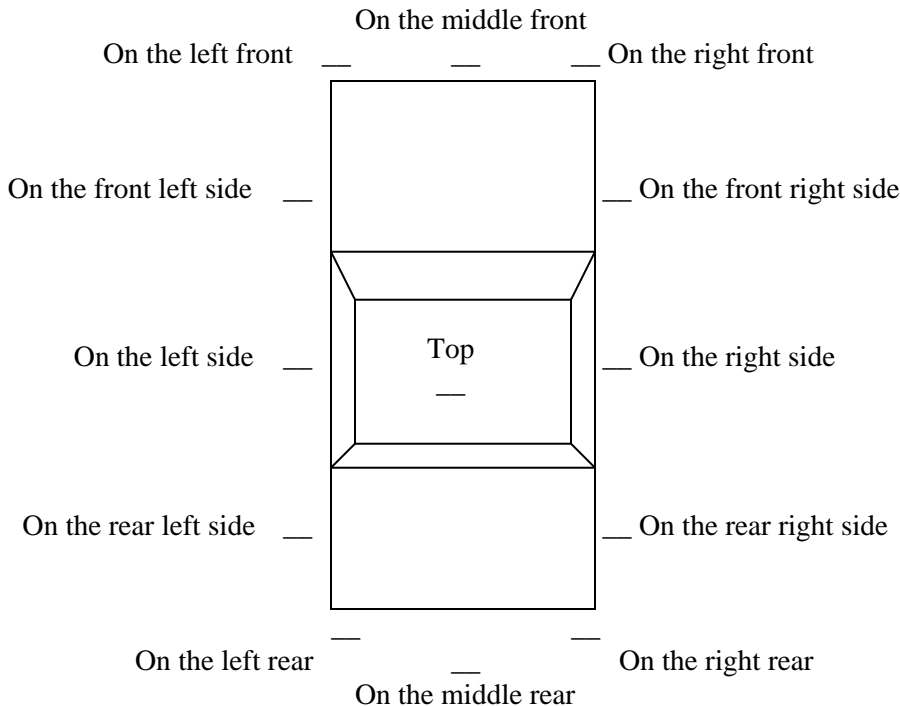
### Was a citation issued as a result of the accident?

No  Yes

### If yes who was at fault?

- Myself
- Driver of the vehicle I was in
- Driver of the other vehicle

### What was the other vehicle's point of impact?

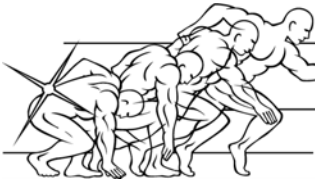


### Were you wearing seat restraints?

- Was wearing a full lap and shoulder restraint
- Was wearing a lap restraint
- Other: \_\_\_\_\_
- Was wearing a shoulder restraint
- Was not wearing any seat restraints

### What position were your vehicle head rests in?

- Did have a head rest which was adjusted in the lowest position
- Did have a head rest which was adjusted in the middle position
- Did have a head rest which was adjusted in the highest position
- Was not equipped with a head rest
- Other: \_\_\_\_\_



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## Did your air bag deploy?

- Air bags were deployed  
 Air bags were not deployed  
 Other: \_\_\_\_\_

## Were you prepared for the impact?

- Was completely surprised by the accident  
 Saw the collision coming and braced appropriately  
 Saw the collision coming  
 Other: \_\_\_\_\_

## What position was your body in just prior to impact?

- Straight forward     Straight with head turned right     Rotated to the right  
 Leaning forward     Straight with head turned left     Rotated to the left  
 A position that cannot be remembered  
 Other: \_\_\_\_\_

## What happened to your body the moment of impact?

- Body whipped violently forward and backward  
 Body was thrown violently from side to side  
 Body violently torqued and twisted backward  
 Body was braced for impact     Body was badly cut and bruised  
 Body was thrown over the seat     Body was thrown from the vehicle  
 Body was pinned in the vehicle     Other: \_\_\_\_\_

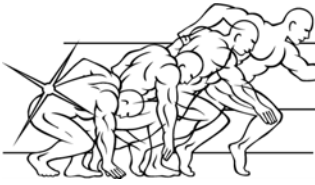
## What was your mental/emotional state immediately following the accident?

- Was not rendered unconscious by the impact of the accident  
 Was not rendered unconscious but was shaken up  
 Was not rendered unconscious but was disoriented  
 Was not rendered unconscious but was shaken and disoriented  
 Was rendered unconscious by the impact of the accident  
 Other: \_\_\_\_\_

List each of your body parts that struck the following vehicle parts during the accident.

## Dashboard: (Please circle right or left)

- R / L side of the head     R / L arm     R / L wrist     R / L knee  
 Forehead     R / L elbow     R / L hip     R / L ankle



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Back of head       R / L shoulder       Other: \_\_\_\_\_

**Windshield:** (Please circle right or left)

R / L side of the head     R / L arm       R / L wrist       R / L knee  
 Forehead                     R / L elbow     R / L hip         R / L ankle  
 Back of head                 R / L shoulder  Other: \_\_\_\_\_

**Steering Wheel:** (Please circle right or left)

R / L side of the head     R / L arm       R / L wrist       R / L knee  
 Forehead                     R / L elbow     R / L hip         R / L ankle  
 Back of head                 R / L shoulder  Other: \_\_\_\_\_

**Right Door:**

R / L side of the head     R / L arm       R / L wrist       R / L knee  
 Forehead                     R / L elbow     R / L hip         R / L ankle  
 Back of head                 R / L shoulder  Other: \_\_\_\_\_

**Left Door:**

R / L side of the head     R / L arm       R / L wrist       R / L knee  
 Forehead                     R / L elbow     R / L hip         R / L ankle  
 Back of head                 R / L shoulder  Other: \_\_\_\_\_

**Seat Frame:** (Please circle right or left)

R / L side of the head     R / L arm       R / L wrist       R / L knee  
 Forehead                     R / L elbow     R / L hip         R / L ankle  
 Back of head                 R / L shoulder  Other: \_\_\_\_\_

**Unknown Object**(Please circle right or left)

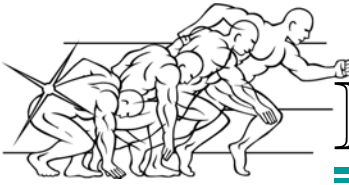
R / L side of the head     R / L arm       R / L wrist       R / L knee  
 Forehead                     R / L elbow     R / L hip         R / L ankle  
 Back of head                 R / L shoulder  Other: \_\_\_\_\_

**Did you receive medical attention at the scene of the accident?**

Did receive medical attention  
 Did not receive medical attention  
 Other: \_\_\_\_\_

**Where did you go immediately following the accident? Circle ( taken or drove self )**

Was taken / drove self to the hospital       Was taken / drove self to a personal physician  
 Was taken / drove self home                     Was taken / drove self to this office



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Resumed activities  Other: \_\_\_\_\_

**If you went to the hospital what treatment did you receive?**

Pain medication  Muscle relaxer  Other \_\_\_\_\_

**Were X-rays taken?**  No  Yes **If yes what views?**  Neck  Mid-back  Low-back  
 Other \_\_\_\_\_

**Have you been treated by any other healthcare professional for this injury?**  No  Yes

**If yes who have you seen?** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**What treatment did you receive?**  Pain medication  Muscle relaxer  Other: \_\_\_\_\_

**Did you have any physical complaints BEFORE THIS ACCIDENT?**  No  Yes

**Please describe how your injuries have affected your daily activities i.e. work, personal care, recreation, social activities, house work, family life etc.**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**On a scale of 0 – 10 ( 0 being no pain 10 being severe pain ) please assign a value to each of the symptoms you are experiencing at this time:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Neck pain              | <input type="checkbox"/> Mid back pain          | <input type="checkbox"/> Low back pain          |
| <input type="checkbox"/> Fainting          | <input type="checkbox"/> Neck stiffness         | <input type="checkbox"/> Mid back stiffness     | <input type="checkbox"/> Low back spasm         |
| <input type="checkbox"/> Double vision     | <input type="checkbox"/> Neck spasm             | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Blurred vision    | <input type="checkbox"/> Shoulder pain          | <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Numbness in toes       |
| <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Pain in rib cage       | <input type="checkbox"/> Sleeplessness          |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Ringing in ears        |
| <input type="checkbox"/> Hearing loss      | <input type="checkbox"/> Upset stomach          |   |   |
| <input type="checkbox"/> Memory loss       | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Other: _____           |   |
| <input type="checkbox"/> Loss of balance   | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Other: _____           |   |