



Abraham Kozma, D.C., P.A.
4010 Sawyer Road * Sarasota * Florida * 34233
Office 941-924-9892 ** Fax 941-924-7283

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR OUR RECORDS

Name: _____

Employer: _____

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? _____

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 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 answer)

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 OF YOUR ABILITY
PLEASE PRINT ALL ANSWERS 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

Patient's Signature _____ Date: _____

Chiropractic and Acupuncture Center of Sarasota
Dr. Abraham I. Kozma
4010 Sawyer Road * Sarasota * Florida * 34233
Office 941-924-9892 *** Fax 941-924-7283

Check 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 nay 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 Signature: _____ Date: _____

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 ever been in an automobile accident before? Y N If yes, please describe, including any injuries received: _____

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?

AUTO: Number of people in your automobile: _____

What direction were you headed 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 Signature: _____ Date: _____

