Essentials of Life Chiropractic

AUTOMOBILE ACCIDENT HISTORY FORM

(Please fill in the appropriate information check the most appropriate answer)

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ am/pm

City and Street(s) of Accident: _____

Road conditions at the time of the accident: ☐ WET ☐ DRY ☐ ICY ☐ OTHER: _____

Did police come to the scene? ☐ YES ☐ NO Is there a report? ☐ YES ☐ NO

Did you go to the hospital? ☐ YES ☐ NO

If yes, what is the name and city of the hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?

☐ AWARE ☐ SURPRISED

Did you lose consciousness (black out) upon impact? ☐ YES ☐ NO

Did you experience a flash of light or explosion in your head? ☐ YES ☐ NO

Did the accident cause you to be/have (check all that apply)?

☐ CONFUSED ☐ NAUSEATED

☐ DISORIENTED ☐ BLURRED VISION

☐ LIGHT HEADED/DIZZY ☐ RING/BUZZ IN EAR

If you still have any of those symptoms, which ones are they? _____

Are you presently suffering from any of the following (check all that apply)?

☐ RESTLESSNESS ☐ IRRITABILITY

☐ DIFFICULTY CONCENTRATING ☐ MEMORY PROBLEMS

☐ SLEEPLESNESS ☐ FOREGETFULNESS

☐ REDUCED TOLERANCE TO HEAT ☐ REDUCED TOLERANCE TO ALCOHOL

How far is the top of the headrest or seat back from the top of your head?

(approximately): _____ inches ☐ ABOVE ☐ BELOW

Were you wearing a seatbelt? ☐ YES ☐ NO
Was it a lap belt and/or shoulder belt? ☐ LAP BELT ☐ SHOULDER BELT

What is the estimated cost of damage to the vehicle you were in? $_____

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

Was your vehicle stopped at the time of impact? ☐ YES ☐ NO
If yes, was the driver's foot also on the brake? ☐ YES ☐ NO
If no, estimate the speed of the vehicle that you were in: _____ MPH
Was your vehicle moving at the time of impact? ☐ YES ☐ NO
Was it slowing down? ☐ YES ☐ NO
Was it gaining speed? ☐ YES ☐ NO
Was it traveling at a steady rate of speed? ☐ YES ☐ NO

Did your body strike any parts of the vehicle? ☐ YES ☐ NO
If yes, describe: _____
_____
Did you sustain any injury or bruises from the seatbelt? ☐ YES ☐ NO
If yes, describe: _____
_____
Which parts of your car were damaged during the accident?
☐ WINDSHIELD ☐ STEERING WHEEL
☐ R/L SIDE WINDOW ☐ FRONT SEAT BACK
☐ OTHER: _____ ☐ OTHER: _____
Was the trunk of your body pointed straight forward at the time of the collision? ☐ YES ☐ NO
If no, how was it turned? _____
Was your head pointed straight forward at the time of the collision? ☐ YES ☐ NO
If no, what direction was it turned and by how much? _____

What was the year, make and model of the other vehicle?
Year _____ Make _____ Model _____

Was the other vehicle moving at the time of impact? ☐ YES ☐ NO
If yes, what was the approximate speed? _____ MPH
If the other vehicle wasn't moving at the time of impact, was it:
Was it slowing down? ☐ YES ☐ NO
Was it gaining speed? ☐ YES ☐ NO
Was it traveling at a steady rate of speed? ☐ YES ☐ NO

Please describe, to the best of your knowledge, what happened during the accident:
_____
_____
_____