Performance Chiropractic

Automobile Accident History Form

Patient Name: _____ Today's Date: _____

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

Road conditions at the time of the accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other _____

Did the police come to the accident scene? ☐ Yes ☐ No

Is there a report? ☐ Yes ☐ No Did you request the report? ☐ Yes ☐ No

Did you got to the hospital? ☐ Yes ☐ No _____

If yes, what 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? ☐ Driver ☐ Front Passenger ☐ Left Rear ☐ Middle Rear ☐ Right Rear

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? ☐ Yes ☐ No If yes, for how long? _____

Did you experience a flash of light or explosion in your head? ☐ Yes ☐ No

Did you become one of the following from the accident?

☐ Confused ☐ Disoriented ☐ Lightheaded ☐ Dizzy

☐ Nauseated ☐ Blurred Vision ☐ Ring/Buzz in ears

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

Are you currently suffering from any of the following?

☐ Difficulty Concentrating ☐ Restlessness ☐ Sleeplessness

☐ Reduced Tolerance to Heat ☐ Difficulty with Memory ☐ Chills

☐ Reduced Tolerance to Alcohol ☐ Irritable ☐ Forgetfulness

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 seat belt? ☐ Yes ☐ No

If yes, was it a ☐ Lap Seatbelt ☐ Shoulder-Lap Seatbelt

List the year, make and model of the vehicle you were in:

Year _____ Make _____ Model _____

Was your car stopped at the time of impact? ☐ Yes ☐ No

If no, then estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it:

Slowing down? ☐ Yes ☐ No

Gaining speed? ☐ Yes ☐ No

Traveling at a steady rate of speed? ☐ Yes ☐ No

On what part of the automobile did your following body parts hit?

Head hit _____ Chest hit _____

Right/left shoulder hit _____ Right/left arm hit _____

Right/left hip hit _____ Right/left leg hit _____

Right/left knee hit _____ Other _____

Did you receive any injury or bruise from the seat belt? ☐ Yes ☐ No

If yes, please describe: _____

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

Which of the following car parts broke during the accident?

☐ Windshield ☐ Front Seatback ☐ Right/Left Side Window

☐ Steering Wheel ☐ 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? ☐ Yes ☐ No

If no, what direction was it turned and by how much? _____

What is the year, make and model of the other vehicle?

Year _____ Make _____ Model _____

Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No

If yes, what was its approximate speed? _____ Mph

If the other vehicle was moving at the time of the collision, was it:

☐ Slowing Down ☐ Gaining Speed ☐ Traveling at a Steady Speed

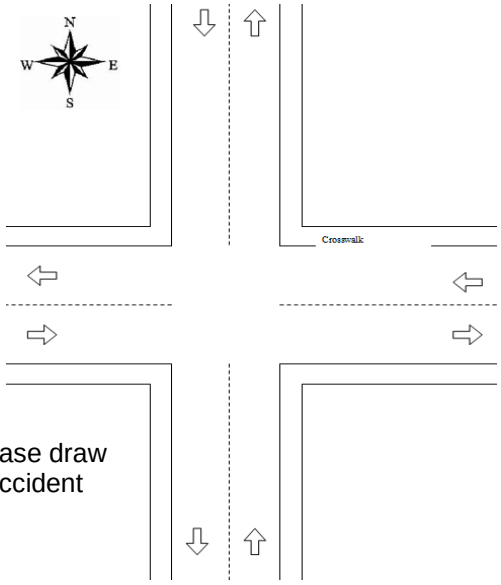
Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

_____



Please draw accident

Thank you for taking the time to fill out this form.