AUTO ACCIDENT INFORMATION

Patient Name _____ Date _____

Date and time of accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear passenger

Make and model of the vehicle you were occupying? _____

Number of people in accident vehicle? _____

Was a police report filed? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

If your vehicle was equipped with air bags, did it inflate? ☐ Yes ☐ No

In relation to the base of your head, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe:

_____

Name of the location/ street on which you were traveling?

_____

What was the approximate speed of your vehicle? _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

_____

_____

AFTER INJURY

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: ☐ D.C. ☐ M.D ☐ D.O ☐ D.D.S

Describe any treatment you received: _____

_____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Memory loss	☐ Headache(s)	☐ Blurred vision
☐ Buzzing in ear	☐ Ears ringing	☐ Difficulty Sleeping	☐ Irritability
☐ Fatigue	☐ Tension	☐ Neck pain	☐ Neck stiff
☐ Jaw problems	☐ Arms/ shoulder pain	☐ Numb hands/fingers	☐ Chest pain
☐ Shortness of breath	☐ Stomach upset	☐ Nausea	☐ Back pain
☐ Lower back pain	☐ Back stiffness	☐ Leg pain	☐ Numb feet/toes

☐ Other:

_____

_____

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____

Date _____/_____/_____