

AUTOMOBILE ACCIDENT HISTORY

Name _____ Preferred Name _____

Address _____

City/State/Zip _____

Home Phone# _____ Cell Phone# _____

Email Address _____

Drivers License # _____ Birthdate _____ Age _____

Date and Time of Accident: _____

Your Automobile Insurance Company: _____

Claim #: _____ Automobile Insurance Phone #: _____

Other Driver's Information

Other Driver's Name: _____ Other Driver's Claim # _____

Other Driver's Insurance Company _____ Insurance Phone # _____

Please state how the accident happened in your own words (please add as much detail as possible):

What was your position in the vehicle?

Driver Front Passenger Rear Passenger Pedestrian

Was it your car? Yes No If not your car, who's? _____

What type of vehicle were you driving? Compact Mid Size Full Size Mini Van

Sm. Truck Lg. Truck Sm. Sport Utility Lg. Sport Utility Motorcycle

Motor Home Bicycle

What was your vehicle doing just prior to the accident?

Stopped at a stop light Slowing down to a stop At a complete stop Increasing speed

Merging into traffic Changing lanes

At what speed were you traveling? _____

At what speed was the other vehicle traveling? _____

What type of road were you on? Two Lane Four Lane Gravel Other: _____

Who Hit Who? You were struck by another vehicle You struck another vehicle

Other _____

Where was your vehicle hit? Front Right Front Left Front Rear Right Rear
 Left Rear Right Side Left Side

What was the other vehicle doing just prior to the accident?

Stopped at a stop light Slowing down to a stop At a complete stop Increasing speed
 Merging into traffic Changing lanes Making a turn

Where was the other vehicle hit? Front Rear Right Side Left Side Right Front
 Left Front Right Rear Left Rear

If your vehicle didn't hit another vehicle, what did you hit? _____

Were you wearing seat belts? Yes No

Full Lap & Shoulder Restraint Lap Restraint Only Shoulder Restraint Only

What position were your vehicle head-rests in?

Lowest Middle Highest No head-rests in vehicle

Did your vehicles air bags deploy? Yes No No air bags in vehicle

Were you prepared for the impact? Came as a complete surprise Aware & braced for collision
 Aware but not braced for collision

Was your vehicle driveable from the scene? Yes No

Was the other vehicle driveable from the scene? Yes No

Were police called to the scene? Yes No

Was anyone ticketed? Yes No **Who?** _____ **For what?** _____

What position was your head and neck in prior to the impact?

Straight forward Tilted forward Rotated to the left Rotated to the right Turned around

What happened to your body at the moment of impact?

Tensed for impact Torqued and twisted Thrown from vehicle Thrown from side to side
 Whipped forward/backward Thrown from seat Pinned in vehicle Cut and bruised

What was your emotional state immediately following the accident?

Shaken Up Disoriented Shaken Up & Disoriented Unconscious

What were your complaints at the time of the accident? (Please check all that apply)

Neck Pain/Stiffness Mid Back Pain Low Back Pain Arm Pain Elbow Pain
 Hand Pain Leg Pain Knee Pain Ankle Pain Foot Pain
 Chest Pain Abdomen Pain Shoulder Pain Headache Nausea
 Dizziness Blurry Vision Buzzing and Ringing in Ears Shortness of Breath
 Stomach Upset Numb Feet/Toes Numb Hands/Fingers Jaw Problems

Did you receive medical attention at the scene of the accident? Yes No

Where did you go immediately following the accident?

Hospital Home Personal Doctor Resumed Daily Activities This Office

Did you go to the hospital? Yes No
 Same Day Went the following day Went Different Day

If you went to the Hospital, how did you get there? Ambulance Private Vehicle

What Hospital? _____

Were you hospitalized? Yes No **If yes, for how long?** _____

What were your complaints at the Hospital? (Please check all that apply)

- | | | | | |
|---|--------------------------------------|---|---|----------------------------------|
| <input type="radio"/> Neck Pain/Stiffness | <input type="radio"/> Mid Back Pain | <input type="radio"/> Low Back Pain | <input type="radio"/> Arm Pain | <input type="radio"/> Elbow Pain |
| <input type="radio"/> Hand Pain | <input type="radio"/> Leg Pain | <input type="radio"/> Knee Pain | <input type="radio"/> Ankle Pain | <input type="radio"/> Foot Pain |
| <input type="radio"/> Chest Pain | <input type="radio"/> Abdomen Pain | <input type="radio"/> Shoulder Pain | <input type="radio"/> Headache | <input type="radio"/> Nausea |
| <input type="radio"/> Dizziness | <input type="radio"/> Blurry Vision | <input type="radio"/> Buzzing and Ringing in Ears | <input type="radio"/> Shortness of Breath | |
| <input type="radio"/> Stomach Upset | <input type="radio"/> Numb Feet/Toes | <input type="radio"/> Numb Hands/Fingers | <input type="radio"/> Jaw Problems | |

Were x-rays performed at the hospital? Yes No

What areas were x-rayed? _____

Were medications prescribed at the hospital? Yes No

If yes, please list the medications prescribed? _____

What treatment did you receive at the hospital? Told to see a doctor if pain continued

Crutches Neck Collar Back Brace Apply Ice Apply Heat Other _____

Have you been seen by any Doctors for this accident? Yes No

What is the name of the Doctor treating you for this accident? _____

For What Condition? _____

Have you had any tests performed? MRI's? Additional X-rays? Etc.? Yes No

What Tests? _____

What treatment have you received? (Please check all that apply)

- | | | | |
|--|---|---------------------------------------|--|
| <input type="radio"/> Chiropractic Manipulations | <input type="radio"/> Electrical Muscle Stimulation | <input type="radio"/> Hot Moist Packs | <input type="radio"/> Cold Packs |
| <input type="radio"/> Traction | <input type="radio"/> Ultra Sound | <input type="radio"/> Massage Therapy | <input type="radio"/> Rehabilitation Exercises |

At this time, how often are you being treated? 3x/week 2x/week 1x/week Other _____

Have you received any chiropractic treatment prior to this current accident? Yes No

If yes, For What and When? _____

Have you had any previous automobile accidents? Yes No

If yes, When? _____

Have you had any Workers Compensation Injuries? Yes No

If yes, When? _____

Have you had any falls? Yes No

If yes, When? _____

