VERNE CHIROPRACTIC CLINIC, PA

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Accident History

Name:____ Date:______/______/______

First **MI** **Last**

In detail describe how this accident happened:____

____

____

____

____

Was there a second collision, such as your car striking another car or an object: ___YES ___NO

Please describe:____

Was there a police report made? ____YES ____NO Was there a citation issued? ____YES ____NO

To whom was the citation issued? _____You ____The other driver

Have you had any other accidents prior to this one? ___ YES ___No Date(s) ___________________

Extent of injuries:____

Treatment:____

Any restrictions or limitations:____

Have you had any other injuries due to falls, sports, work, etc.? ____YES ___NO Date(s)__________

____

____

Current Auto Accident Details:

Date of accident:_______________________ Time of Day:________________weather condition;__________________

Were you the: _____Driver _____ Passenger _____Pedestrian

Body position in impact: ____

Was your car stopped or moving?____________________________ Approx. how many MPH:__________________

Were you wearing your seat belt? __________________ Position of head on impact?____________________

Position of arms/hands on impact?____

Your car was hit from: ____Behind ____Front ____Right side ____Left side ____Parked

Were brakes applied: ___Yes ____No ____Lightly ____Hard

Did any of your body strike the car's interior? ___YES ___NO ____________________________

Was there any loss of consciousness? ___YES ___NO How Long?___________________________

What were the moments like immediately following the accident? _____________________________

____

Did you go to the Hospital/Doctor ____NO ____YES, _____Immediately _____Later, when______________

Other Doctors seen?_______________________________ When_________________________________

Type of treatment(s)____

Make. model and year of your vehicle involved in accident:____________________

Make, model and year of other vehicle involved in accident:____________________

Estimated property damage to your vehicle ____________ was your car drivable? ____YES ____NO

Were there other occupants in the vehicle? ___YES ___NO Who:____________________

Were they also injured? _____NO ____YES ____________________

Check Symptoms you may have noticed since the accident:

____Headaches	____Loss of Taste	____Lower Back Pain
____Neck Pain	____Pins & Needles in arms	____Pins & Needles in Legs
____Neck Stiffness	____Hands/Fingers Numb	____Feet/Toes Numb
____Dizziness	____Loss of memory	____Stomach upset
____Fainting	____Fever	____Diarrhea
____Head feels heavy	____Mid back pain	____Constipation
____Ringing in ears	____Shoulder pain __LT __RT	____Sleeping problems
____Depression	____Chest Pain	____Loss of Balance
____Fatigue	____Shortness of Breathe	____Cold Sweats
____Sensitive to light	____ Nervousness	____Irritability
____Blurred vision	____Loss of smell	____Sciatica
____ Other____________		

What is your primary symptom since accident?____________________

What makes symptom worse?____________________

What makes symptom better?____________________

Do you have pain constant or intermittent? ____________________

What are your current limitations or restrictions from this accident?____________________

____

Did you lose any days from work due to this accident? ____YES ____NO How many days ____________

My Insurance Company: ____________________

Name of insured: ____________________ Insured's Date of birth:____________

Has a claim for this accident already been made? ____YES ____NO Claim #____________

Are you being represented by an attorney for this accident? ____YES ____NO

Name of Attorney:____________________ Phone # ( ) ____________

Doctor comments:____________________

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____

____

Print Name

____________________ ______/______/______

Patient Signature **Date**