Automobile Accident Name: ___________________________________

ROCKRIDGE FAMILY CHIROPRACTIC

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Dr. Douglas Ross D.C. Dr. Virginia Frederick D.C.

1. What was the date of the accident?______________________
2. What time did the accident occur?_______________________
3. How many vehicles were involved in the accident?____________________
4. What was the estimated damage to the vehicle you were in? _______________
5. What state did the accident occur in? __________________________________
6. What city did the accident occur in? ___________________________________
7. What street or intersection were you on when the accident occurred? ________________________
8. What direction were you traveling in? _____________________________________
9. What type of impact was the auto accident? _____________________________________
10. Did your vehicle hit anything after the accident? if yes, please describe ___________________________________
11. Where were you sitting in the vehicle during the accident? ___________________________________
12. Did you know the accident was coming?_______________________________
13. What type of vehicle were you in? _____________________________
14. What type of vehicle impacted yours? ___________________________
15. At the time of the impact, how fast was your vehicle moving? __________________
16. At the time of impact, how fast was the other vehicle moving? _________________
17. During and after the crash what happened to your vehicle? (circle all that apply)
    - kept going straight
    - spun around
    - kept going straight hitting a car in front
    - spun around and hit a stationary object
    - was hit by another vehicle
    - hit a stationary object
18. Did you lose consciousness during the accident? -yes - no
19. How was your head positioned during the accident? _______________________________
20. How was your torso positioned during the accident? _______________________________
21. How were your hands positioned during the accident? ______________________________
22. Did your head hit anything during the accident? -no - yes, please describe______________
23. Did your face hit anything during the accident? -no - yes, please describe_______________
24. Did your shoulders hit anything during the accident? -no - yes, please describe__________
25. Did your neck hit anything during the accident? -no - yes, please describe______________
26. Did your chest hit anything during the accident? -no - yes, please describe______________

27. Did your hips hit anything during the accident? -no - yes, please describe_______________

28. Did your knees hit anything during the accident? -no - yes, please describe______________

29. Did your feet hit anything during the accident? -no - yes, please describe________________

30. What kind of headrest was in your vehicle?
    - movable fixed headrest
    - nonmovable fixed headrest
    - no headrest

31. Where was the headrest positioned on your head? ________________________________

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? ___________________________

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totaled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
    - floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
    - front left - front right
    - rear left - rear right

37. Did you go to the hospital? If no, list any other Health Care Providers seen for this accident and why
____

If seen at a Hospital:

38. How did get to the hospital? ____________________________________

39. What was the name of the hospital? ______________________________

40. Were you hospitalized over night? _________________________________

41. Circle what you were prescribed at the hospital
    - pain medication - muscle relaxers - neck brace

42. Did you receive any stitches for any cuts at the hospital? ____________________

43. Were x rays taken at the hospital? If yes, which area was taken and results (if known)?
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Signed_______________________________________ Date____________