RYAN CHIROPRACTIC

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Automobile Accident Description

Please answer the following questions. Skip the question if you do not know the answer.

1. Date of Accident: _____

2. At what time of day did your accident take place? _____ AM / PM

3. Road conditions at the time of the accident were:

   Check one: ___ Icy, ___ Wet, ___Sandy, ___ Clean and Dry, Other _____

4. Visibility was: ___ Good, ___ Good but it was dark out, ___ Fair, ___ Poor

5. Total number of vehicles involved _____

6. Your Vehicle (#1) Year _____ Make _____ Model _____

7. Other Vehicle (#2) Year _____ Make _____ Model _____

(If applicable)

8. Other Vehicle(#3) Year _____ Make _____ Model _____

9. Other Vehicle(#4) Year _____ Make _____ Model _____

10. Where were you seated in the vehicle? _____

11. Who else was in your vehicle and where were they seated? _____

_____

12. Describe what happened: _____

_____

_____

_____

_____

13. What was your vehicle's speed? _____ mph

14. What was your vehicle's point of impact? _____

15. Damage to your vehicle was: (circle one) None Mild Moderate Totaled

Name: _____

16. What was the other vehicle's speed? _____ mph

17. What was the other vehicle's point of impact? _____

18. Damage to the other vehicle was: (circle one) None Mild Moderate Totaled

19. Did police respond to the scene? ___ No, ___ Yes

20. Was any driver given a citation or arrested? ___ No, ___ Yes

If yes, who: _____

21. Was an Accident report filled out? ___ No, ___ Yes

22. Did an ambulance come? ___ No, ___ Yes

23. Did you receive medical attention at the scene? ___ No, ___ Yes

24. Where did you go right after the accident? _____

25. How did you get there? _____

26. Were any of the vehicles towed from the scene? (Explain) _____

_____

- Patient Information

1. Did you see the accident coming? ___ No, ___ Yes, ___ Yes, but I didn't have time to react

2. Did you hear the screeching of tires prior to the impact? ___ No, ___ Yes, ___ I don't remember

3. Were you braced for the impact? ___ No, ___ Yes

4. Was your foot on the brake at the time of impact? ___ No, ___ Yes, ___ N/A

If yes, was it knocked off of the brake? ___ No, ___ Yes, ___ I don't remember

5. Does your car have a manual transmission? ___ No, ___ Yes, ___ N/A – I wasn't the driver

If yes, was your left foot pressing the clutch at the time of impact?

___ No, ___ Yes, ___ I don't remember

Was you foot knocked off of the clutch? ___ No, ___ Yes, ___ I don't remember

Did your vehicle stall? ___ No, ___ Yes, ___ I don't remember

6. If you were hit from behind, was your vehicle pushed forward? ___ No, ___ Yes

If yes, how far? _____

7. Were you wearing a seatbelt? ___ No, ___ Yes

If yes, what type? ___ Just a lap belt, ___ Lap belt with shoulder strap

8. Did the airbags deploy? ___ No, ___ Yes, ___ N/A

9. Does your vehicle seat have a head restraint? ___ No, ___ Yes

If so, what was the position of the headrest at the time of impact? (check all that apply)

___ Even with the top of your head ___ Even with the bottom of your head

___ Even with the middle of your neck ___ All the way up

___ All the way down ___ I don't remember

10. My seat was (Check one):

___ All the way forward ___ All the way back ___ In the middle ___ I don't remember

11. My seatback was (Check one):

___ Upright ___ Laid back partially ___ Laid back fully ___ I don't remember

12. What direction was your head facing at the time of the impact?

___ Turned to the left ___ Turned to the right ___ Facing Forward ___ I don't remember

13. Did your body strike the inside of the vehicle? ___ No, ___ Yes

If yes, describe: _____

14. Did you lose consciousness during the accident? ___ No, ___ Yes (how long_____)

15. Check off any of the following that apply to your crash:

___ My hat or glasses were knocked off of my head

___ My drink spilled

___ Change was knocked out of an ashtray or cupholder onto the floor

___ My purse or personal belongings fell off of the seat

___ My dashboard/windshield mounted navigation device fell out of its holder

___ My seatback failed / my seat broke

- **Symptoms**

Check off any symptoms that you had right after the accident or within a few days after.

___ Neck Pain	___ Headache	___ Low Back Pain	___ Dizziness
___ Neck Stiffness	___ Confusion	___ Fainting	___ Mid Back Pain
___ Fatigue	___ Tension	___ Ringing in the Ears	___ Constipation
___ Diarrhea	___ Cold Hands	___ Cold Feet	___ Depression
___ Nausea	___ Nervousness	___ Anxiousness	___ Chest Pain
___ Loss of Smell	___ Irritability	___ Loss of Taste	___ Sleeping Problems
___ Sciatica	___ Toe Numbness	___ Eye Pain	___ Problems Breathing

Other: _____

- **Primary Treatment History**

1. I went/was taken to the hospital. ___ No, ___ Yes

Hospital Name: _____

2. Date you were seen: _____

3. How did you get there: _____

4. Were x-rays done? ___ No, ___ Yes – if yes, of what? _____

5. What did the x-rays reveal? _____

6. Was a CAT scan or MRI done? ___ No, ___ Yes – if yes, of what? _____

Was any lab work done (blood/urine)? ___ No, ___ Yes – if yes, what? _____

7. Were you given medications while you were there? ___ No, ___ Yes

   – if yes, list names / dosages? _____

8. Were you given a prescription(s)? ___ No, ___ Yes

   – if yes, list names / dosages? _____

What were your follow up instructions? _____

- **Other Treatment History**

1. Hospital / Doctor Name: _____

2. Date you were seen: _____

3. Were x-rays done? ___ No, ___ Yes – if yes, of what? _____

4. What did the x-rays reveal? _____

5. Was any lab work done? ___ No, ___ Yes – if yes, what? _____

6. Were you given medications or prescriptions? ___ No, ___ Yes

   – if yes, list names / dosages? _____

7. Type of treatment received: _____

8. Did the treatments help? ___ Yes, ___ No – if no explain _____

9. Are you still treating there? ___ No, ___ Yes

10. Follow up instructions: _____