# Auto Accident History

FIT FAMILY CHIROPRACTIC

**First and Last name:**_____

**Date of accident:**_____ **Time of accident:**_____
**Were the police at the accident?** Yes No **Is there a police report?** Yes No
**Road conditions:** Wet Dry Snow Ice Other_____
**Was the accident on the job?** Yes No **Were you in a company vehicle?** Yes No
**Where were you seated in the vehicle?** Driver Passanger Rear Other_____
**Were you aware of the approching collision prior to impact?** Yes No

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**List the make and model or type of the vehilcle that you were in:**
MAKE:_____ MODEL: _____ TYPE:_____
**Was your car moving at the time of impact?** Yes No
**If yes, what was the approximate speed of the vehicle :** _____ MPH

**At the time of impact, was the car:** Slowing Down Gaining Speed Steady Speed

**List the, make and model or type of the car also involved in the accident :**
MAKE:_____ MODEL: _____ TYPE:_____
**Was the other car moving at the time of impact?** Yes No
**If yes, what was the approximate speed of the vehicle :** _____ MPH

**At the time of impact, was the other car:** Slowing Down Gaining Speed Steady Speed

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**Please describe, to the best of your knowledge, what happened during this accident.**

_____

_____

_____

_____

_____

You may draw the accident here

**Were you wearing a seatbelt?** Yes No
**If yes, are you bruised from the seatbelt?** Yes No
**Did your head hit the head rest during the accident?** Yes No
**Did you lose conciouseness?** Yes No
**If adjustable, was the position of the head rest altered?** Yes No

**Did the air-bag deploy?** Yes No **If yes, did it strike you?** Yes No
**Which way was your head pointing at the point of impact?** Straight Right Left
**Body?** Straight Right Left
**Did any other part of body hit the interior of vehicle?** _____
**If yes, what body part where**?_____

**Where were your hands?** One on the wheel Both on the wheel Not Applicable

**Were you wearing a hat or glasses at the time of impact?** Yes No
**If yes, were they still on after the accident?** Yes No
**Amount of vehicle damage:** Totaled Heavy Moderate Slight No Damange

**Name of their auto insurance:**_____ **Claim #:**_____

**Name of insurance adjuster:**_____

**Auto insurance phone #:**_____ **Auto insurance fax #:**_____

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**<u>At the time of the accident</u>, did you become or experience any of the following?**

Confused Disoriented Light Headed Dizzy Nauseated Blurred Vision

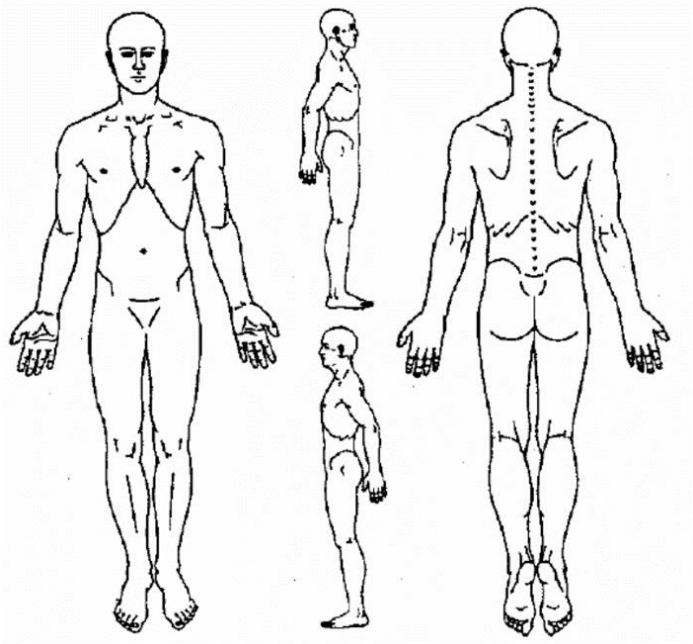
Ringing/Buzzing in Ears Loss of Balance Pain Other:_____

**Do you still have any of those symptoms?** Yes No **If Yes, which ones?** _____

Circle symptoms you have noticed since the accident:

| | | | | |
|---|---|---|---|---|
| Headaches/Migraines | Neck Pain | Upper Back Pain | Shoulder Pain | Midback Pain |
| Low Back Pain | Depression | Buzzing In Ears | Arm/Leg Pain | Jaw Pain/Clicking |
| Dizziness | Fatigue | Loss of Memory | Cold Hands/Feet | Numbness/Tingling |
| Loss of Smell | Irritability | Digestive Problems | Joint Pain/Stiffness | Menstrual Problems |
| Pinched Nerve | Loss of Sleep | Loss of Balance | Chest Pain | Light Bothers Eyes |
| Fever | Nervousness | Vision Problems | Urinary Problems | Sleeping Problems |
| Paralysis | Tension | Fainting | Pins/Needles Feeling | Stomach Upset |
| Difficulty Swallowing | Sciatica | Sinus Pain | Sore Muscles | Head Feel Heavy |

**Please circle the area of injury or discomfort on the chart**



**Pain Intensity:**

**Last 24 Hours:** No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

**Past Week:** No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain