

DISCOVER CHIROPRACTIC – AUTOMOBILE ACCIDENT HISTORY FORM

Patient: _____ DOB: _____ Date: _____

Accident Information

Date of Accident _____ Time of Accident _____

City of Accident _____ Street of Accident _____

Road conditions at the time of accident Wet Dry Icy Other _____

Did the Police come to the scene? Yes No Is there an accident report? Yes No

Medical Information

Did you seek medical care? Yes No Day/Time _____

Did you go via ambulance? Yes No Did you stay over night? Yes No

Name of Doctor _____ Name of Facility _____

Address _____ Phone _____

Did you have X-rays? Yes No If Yes, what body parts were X-rayed _____

Any other tests? Yes No If Yes, please list _____

What treatment did you receive? _____

How long did you stay at the hospital? _____

Injury Information

Did you break any bones? Yes No Did you have any cuts or bleeding? Yes No

Did you lose Consciousness? Yes No Did you have any bruises? Yes No

Did you become Dizzy Confused Nauseated Disoriented Lightheaded

Did you have Blurred vision Ringing in ears

Accident Mechanism

Were you the Driver Passenger (Front / Rear) Were you at fault? Yes No

Did you see the accident coming? Yes No If yes, did you brace yourself for it? Yes No

Were you wearing a seat belt? Yes No If yes, was it a Lap belt or Shoulder harness

Did you hit anything in the car? Yes No If yes, describe _____

Were you Rear-ended T-boned Side-swiped Front-ended Other _____

How far is the headrest from the back of your head? _____ inches

Were you intoxicated at the time of the crash? Yes No

Was your head pointing straight forward at impact? Yes No If no, what direction was it facing _____

Was the car stopped at impact? Yes No If yes, was the driver's foot on the brake? Yes No

Estimate the speed your car was going at impact _____ mph

Were you speeding up slowing down moving at a constant speed

Vehicle you were in: Year _____ Make _____ Model _____

What is the estimated damage to the vehicle \$ _____

Circle all that apply: Single-Car Crash Two-vehicle Crash More than 3 vehicles
Rear-ended Side Crash Rollover
Head-on Injury Hit guardrail/tree Ran off road

The Other Vehicle Information

Estimate the speed of the other car involved in the accident _____ mph

Were they speeding up slowing down moving at a constant speed

The other Vehicle: year _____ Make _____ Model _____

