Innate Chiropractic Healing Arts Center
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Automobile Accident Injury Report

Patient's Full Name _____ Date of Birth _____ / _____ / _____

Date Of Accident: _____ / _____ / _____ Time Of Accident: _____:_____ ❒AM ❒PM

PLEASE EXPLAIN HOW THE ACCIDENT HAPPENED INCLUDING CAUSE/S AND SURROUNDING CIRCUMSTANCES:

_____

_____

_____

_____

Type of vehicle were you in when involved in the accident? ❒Car ❒Truck ❒SUV ❒Bus ❒Motorcycle ❒Bicycle
What other type vehicle/s was/were involved? ❒Car ❒Truck ❒SUV ❒Bus ❒Motorcycle ❒Bicycle
Were you a: ❒Driver ❒Passenger ❒Pedestrian ❒Cyclist
If a passenger, please indicate your location in car: ❒Front Passenger ❒Back-Drivers Side ❒Back-Passenger Side
Number of passengers in your vehicle: _____ Were you "buckled up"? ❒Yes ❒No
Was your vehicle moving when the accident occurred? ❒Yes ❒No If so, how fast? _____
Was the other vehicle moving when the accident occurred? ❒Yes ❒No If so, how fast? _____
Did your vehicle hit other vehicle/s? ❒Yes ❒No Where? _____
Did other vehicle/s hit your vehicle? ❒Yes ❒No Where? _____
Impact to your vehicle was from: ❒Behind ❒Front ❒Right Side ❒Left Side
Did your seat have a headrest: ❒Yes ❒No
Were you: ❒Surprised by the impact ❒Braced for the impact
At the time of the impact were you looking: ❒Straight ahead ❒To the left ❒To the right ❒Up ❒Down
Did any part of your body strike anything in the vehicle: ❒Yes ❒No Explain? _____
Were the police notified: ❒Yes ❒No Was a police report filed: ❒Yes ❒No
Were traffic citations issued: ❒Yes ❒No If yes, to whom: _____

Your Health Following the Accident

Were you knocked unconscious: ❒Yes ❒No If yes, for how long: _____
Did your head strike the windshield or any object: ❒Yes ❒No Explain: _____
When did you feel pain: ❒Immediately ❒Later that day ❒Next day ❒Other _____
Where did you feel pain after the accident: _____
Were you taken to the emergency room? Did you require post-accident hospitalization: ❒Yes ❒No
If yes, what treatment was given: _____
Have you seen any other doctor for injuries from this accident: ❒Yes ❒No Who? _____
What was done? Their diagnosis: _____
Are you still treating with this doctor? ❒Yes ❒No
Were any of the following taken: ❒X-Rays ❒MRI ❒CT Scan ❒Other _____
Have you had complaints in the involved area before? ❒Yes ❒No _____
Have you had similar accidents or injuries before? ❒Yes ❒No _____
Are your activities restricted because of the accident: ❒Yes ❒No _____
Since the accident, are your symptoms: ❒Improving ❒Getting Worse ❒The Same

Present Complaints Related to This Accident

Check all symptoms related to the accident and rate the severity of each on a scale of 1 – 10 with 10 being the worst.

❒Headache _____
❒Head seems too heavy _____
❒Head/shoulders tired/heavy _
❒Mental dullness _____
❒Loss of memory _____
❒Equilibrium problems _____
❒Dizziness _____
❒Fainting _____
❒Tremors _____
❒Palpitation _____
❒Neck pain _____
❒Neck stiffness _____
❒Neck motion restricted _____
❒Upper back pain/stiffness ___
❒Low back pain/stiffness ____

❒Pins/needles in arms/legs __
❒Numb in fingers/arms/legs __
❒Chest pain _____
❒Shortness of breath _____
❒Eye strain _____
❒Pain behind eyes _____
❒Eyes sensitive to light _____
❒Eyes loss of focus _____
❒Double vision _____
❒Ears buzzing/ringing _____
❒Loss of taste _____
❒Loss of smell _____
❒Sinus trouble _____
❒Extreme nervousness _____
❒Tension _____

❒Anxiety _____
❒Extreme Fatigue _____
❒Insomnia _____
❒Neuritis _____
❒Face Flushed _____
❒Face Pale _____
❒Excess Perspiration _____
❒Digestive Disorders _____
❒Nausea/Vomiting _____
❒Diarrhea _____
❒Constipation _____
❒Depression _____
❒Swelling _____
❒Feet/Hands Cold _____
❒Fear of Driving/Riding ____

❒Difficulty or ❒Pain with: ❒Standing ❒Walking ❒Riding ❒Bending ❒Other _____
❒Stiffness or ❒Pain upon rising in: ❒Neck ❒Mid back ❒Low back ❒Other _____
❒Pain radiating into ❒Head or neck ❒Base of skull ❒Right arm ❒Left shoulder ❒Right shoulder ❒Left arm ❒Right arm ❒Left hand ❒Right hand ❒Left buttocks ❒Right buttocks ❒left hip ❒Right hip ❒Left leg ❒Right leg ❒Left foot ❒Right foot ❒Other or Explain_____
❒Difficulty in excessive lifting ❒Light ❒Moderate ❒Heavy ❒Repetitive
❒Symptoms other than above: _____

_____

_____

Is there anything else that you would like to tell the doctor so that she may better understand you as a person or your symptoms related to the accident? _____

_____

_____

REGARDING INSURANCE & PAYMENT FOR SERVCIES RENDERED:

I have reported this accident to my insurance company? ❒Yes ❒No

I have an attorney representing me in this case? ❒Yes ❒No

I will and I understand that I am required to pay all fees on the date that services are rendered. ❒Yes ❒No

I understand that this office does not bill any form of insurance nor operate on a lien from an attorney and that I am responsible for payment of all services rendered, regardless of any insurance reimbursement that I may or may not receive. ❒Yes ❒No

I understand that this office does not bill any form of insurance and that I am responsible for payment of all services rendered regardless of any insurance reimbursement that I may or may not receive. ❒Yes ❒No

Patient's Signature: _____ Today's Date: _____ / _____ / _____