Element
Chiropractic

Automobile Accident History

Name: _____ Date: _____

Accident Details

Date of Accident: _____ Time of Accident: _____ am / pm

____Daylight ____ Dawn ____Dusk ____Dark

Was the accident on the job? Yes / No Were you in a company vehicle? Yes / No

Where were you seated in the vehicle? ____Driver _____Passenger ____Rear-Seat ____Other

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ____Aware ____Surprise

Did you lose consciousness upon impact? Yes / No

Did you experience a flash of light or explosion in your head? Yes / No

Were you wearing a seatbelt? Yes / No If yes, did the seatbelt bruise or injure you? Yes / No

Did your head hit the head rest during the accident? Yes / No

If adjustable, what was the position of the headrest? ____Lowered _____Mid-level ____Highest position

Was the seat adjustment altered by the accident? Yes / No Was the seat broken by the accident? Yes / No

Did the airbag deploy? Yes / No If yes, did it strike you? Yes / No If yes, where? _____

Which way was your head pointing at the point of impact? ____Straight ____Right ____Left

Which way was your body pointing? ____Straight ____Right ____Left

If you were the driver, where were your hands? ____ One on the wheel ____Both on the wheel ____Not on the wheel

Were you wearing a hat or glasses at the time of impact? Yes / No Were they still on after the accident? Yes / No

Post-Accident Details

Did you go to the hospital? Yes / No Which hospital? _____

When? ____Immediately ____Hours later ____Days later (fill in how many days or hours)

How did you get to the hospital? _____

What did the hospital do for your injuries? (Collar, splint, x-rays, medication, etc.)_____

_____

What areas were x-rayed or imaged? _____

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What diagnosis were you given? _____

_____

Was any other doctor consulted after your accident? Yes / No If so, please complete the following information:

Dr. _____ Specialty_____ Date first seen_____

Type of treatment_____

Frequency_____How long did you treat? _____

Dr. _____ Specialty_____ Date first seen_____

Type of treatment_____

Frequency_____How long did you treat? _____

Vehicle Details

Car you were in: Year_____ Make_____ Model_____

Was your car stopped at the time of impact? Yes / No If yes, was the driver's foot on the brake? Yes / No / Unknown

If your vehicle wasn't stopped, estimate the speed you were traveling. _____mph

If your vehicle was moving at the time of impact, was it: ____ Slowing down ____ Gaining speed ____ Steady speed

The other car: Year_____ Make_____ Model_____

Was the other car moving at the time of impact? Yes / No If yes, what was the approximate speed? _____mph

At the time of impact, was the other car: ____ Slowing down ____ Gaining speed ____ Steady speed

Any other relevant information: _____

_____

Auto Insurance Information

Driver of the vehicle you were in: _____ Name of their auto Insurance: _____

Policy # _____ Claim #_____

Auto insurance phone number: _____ Adjuster's name: _____

Driver of other vehicle: _____ Name of their auto Insurance: _____

Policy # _____ Claim #_____

Auto insurance phone number: _____ Adjuster's name: _____

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Symptoms

At the time of the accident, did you become or experience any of the following? (Circle all that apply) Confused *Disoriented Nauseated Dizzy Light-headed Blurred vision Ringing/buzzing in ears Loss of balance 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	Head feels too heavy	Loss of memory	Cold hands/feet	Loss of smell
Numbness/tingling	Irritability	Digestive problems	Joint pain/stiffness	Pinched nerve
Menstrual problems	Loss of sleep	Loss of balance	Light bothers eyes	Chest pain
Sleeping problems	Nervousness	Visions problems	Urinary problems	Fever
Paralysis	Tension	Fainting	Pins/needles feeling	Sciatica
Stomach upset	Difficulty swallowing	Sinus pain	Sore muscles	Fatigue

Other: _____

_____

_____

Accident Description:

Please describe, to the best of your knowledge, what happened during this accident. Feel free to use the back of this page, or to draw pictures:_____

_____

_____

_____

_____

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