CARE CHIROPRACTIC, P.C.
Vehicle Accident Information

Patient Information

Patient Name_____Date_____

Date of Accident_____Time of Accident_____ ___AM ___PM

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ___Driver ___Front Passenger ___Rear Passenger ___Pedestrian How many people were in accident vehicle?_____

Accident Site

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions:___Dry ___Wet ___Icy ___Other_____

Which direction were you headed?_____

Speed you were traveling?_____

Vehicle

Make and model of vehicle you were in:_____

_____

Were you wearing a seat belt? ___Yes ___No

If yes, what type? ___Lap ___Shoulder

Was the vehicle equipped with air bags? ___Yes ___No

If yes did it inflate properly? ___Yes ___No

Did your seat have a headrest? ___Yes ___No

If yes, what was the position of the headrest?

___Low ___Mid position ___High

Impact

Did your car impact another vehicle? __Yes ___No

Did your car impact a structure? ___Yes ___No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle? __Yes __No If yes, explain_____

_____

Was impact from:

__Front __Rear __Left __Right __Other_____

At the time of impact were you:

__Looking straight ahead __Looking to the right

__Looking to the left __Looking down

__Looking up

Were both hands on the steering wheel? _Yes __No

If no, which hand was on the wheel? __Rt __Lft

Was your foot on the brake? ___Yes ___No

If yes, which foot was on the brake? __Rt __Lft

Were you: ___Surprised by impact ___Braced for impact

Other Vehicle(If applicable)

Make and model of other vehicle_____

Which direction was the other vehicle headed?_____

_____

Speed other vehicle was traveling_____

Police

Did the police come to the accident site?_Yes __No

Were there any witnesses? ___Yes ___No

Was a police report filed? ___Yes ___No

Was a traffic violation issued? ___Yes ___No

If yes, to whom?_____

-OVER-

Patient Condition

Were you unconscious immediately after the accident? ___Yes ___No If yes, for how long?_____

Please describe how you felt immediately after the accident:_____

_____

_____

_____

Treatment

Did you go to the hospital? ___Yes ___No

When did you go? ___Immediately after accident ___Next day ___2 days or more after the accident

How did you get to the hospital? ___Ambulance ___Private transportation

Name of hospital_____Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

Symptoms/Injuries

Have you been able to work since the injury ___Yes ___No How many days have you missed?_____

Prior to the injury were you able to work on an equal basis with others your age? ___Yes ___No

If you have had any of the following symptoms since your injury, please check:

___Arm/shoulder pain	___Feet/toe numbness	___Neck pain	___Fatigue
___Back pain	___Hand/finger numbness	___Neck stiff	___Memory loss
___Back stiffness	___Headaches	___Shortness of breath	___Nausea
___Dizziness	___Irritability	___Sleep difficulty	___Vision blurred
___Ear ringing	___Jaw problems	___Stomach upset	___Chest pain
___Ear buzzing	___Leg pain	___Tension	

Is this condition getting progressively worse? ___Yes ___No ___Unknown

Does it interfere with your: ___Work ___Sleep ___Daily routine ___Recreation

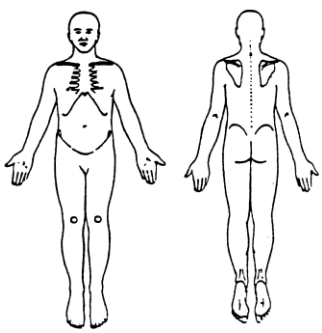
Activities or movements that are painful to perform: ___Sitting ___Walking ___Bending ___Lying down

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting
___Burning ___Tingling ___Cramps ___Stiffness ___Swelling ___Other

How often do you have these symptoms?_____

Please mark areas of pain or injury on the illustrations to the right and give a word description of the symptoms you are experiencing in those areas.



Other Comments:_____

_____

_____

_____

CARE CHIROPRACTIC, P.C.

Vehicle Accident Information (Cont.)

Legal Information

Have you retained an attorney? ___Yes ___No Attorney Name_____

Address_____City_____

State_____Zip Code_____

Insurance

Name of your Health insurance company?_____

Address_____City_____

State_____Zip Code_____ ID# _____Group# _____

Name of your Auto insurance company?_____

Address_____City_____

State_____Zip Code_____Policy #_____

Claim # _____ Adjuster _____Phone _____

Name of other person who was in accident Auto insurance company?_____

Address_____City_____St

ate_____Zip Code_____Policy # _____

Claim # _____Adjuster _____Phone _____

I certify that the information I provided is correct to the best of my knowledge.

Patient's Signature_____Date_____