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 ______________________

Your Account of the Accident

Please describe how the crash happened in your own words:

____
____
____
____
____
____
____
____
____
____

Please draw the intersections, and how the accident happened:

Insurance Information

Your Insurance Information:

Name:_________________________________ Policy Number__________________________

Address:_______________________________ Phone:______________________________

_____________________________________ Agent/Adjuster: _______________________

Have they been contacted about the accident? ❒ Yes ❒ No

The Insurance company handling your claim: ❒ same as above

Name:_________________________________ Policy Number__________________________

Address:_______________________________ Phone:______________________________

_____________________________________ Agent/Adjuster: _______________________

Claim Number: __________________________

Signature ____ Date ______________________

(Guardian if a minor)