Frederick
Chiropractic

AUTOMOBILE ACCIDENT HISTORY FORM

Your Name: _____ Today's Date: _____

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

City of Accident: _____ Street of Accident: _____

Road conditions at the time of the accident: WET DRY ICY OTHER:_____

Did the police come to the accident scene? YES NO Is there a report? YES NO

Did you go to a hospital? YES NO

If yes, what is the name & city of the hospital? _____
How did you get to the hospital? _____
What parts of your body were x-rayed at the hospital? _____
What did the hospital do for your injuries? _____
How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were *you* seated in the vehicle? _____

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

AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO; How long: _____

Did you experience a flash of light or explosion in your head? YES NO

Did you become any of the following from the accident? (please circle)

CONFUSED	DISORIENTED	DIZZY
RING / BUZZ IN EARS	BLURRED VISION	LIGHT HEADED
		NAUSEATED

If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following? (please circle)

RESTLESSNESS	DIFFICULT CONCENTRATING	SLEEPLESSNESS
IRRITABLE	REDUCED TOLERANCE TO HEAT	FORGETFULNESS
DIFFICULT WITH MEMORY	REDUCED TOLERANCE TO ALCOHOL	

How far is the top of the headrest or seatback from the top of your head? (approximately)

_____ inches ABOVE or BELOW.

Were you wearing a seatbelt? YES NO

If yes, was it a lap seatbelt _____ shoulder-lap seatbelt _____

List the year, make, and model of the vehicle you were in:

Year _____ make _____ model _____

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, then estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it:
Slowing down? YES NO Gaining speed? YES NO
Traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?
Head hit _____ chest hit _____
Right / left shoulder hit _____ right / left arm hit _____
Right / left hip hit _____ right / left leg hit _____
Right / left knee hit _____ other _____

Did you receive any injury or bruise from the seatbelt? YES NO, If yes, then describe_____
_____

What is the estimated cost damage to the vehicle you were in? $_____

Which of the following car parts broke during the accident? (please circle)
Windshield front seat back
Right / left side window other _____
Steering wheel other _____

Was the trunk of your body pointed straight forward at the time of the collision? YES NO
If no, how was it turned? _____

Was your head pointed straight forward? YES NO; If no, what direction was it turned and by how much?_____

What is the year, make, and model of the *other* vehicle?
Year _____ make _____ model _____

Was the other vehicle moving at the time of the collision? YES NO
If yes, what was its approximate speed? _____mph

If the other vehicle was moving at the time of the collision, was it (please circle):
Slowing down gaining speed traveling at a steady pace

Please describe, to the best of your knowledge, what happened during this accident:_____
_____
_____
_____

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