Bath City Chiropractic Clinic

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident_____ Time of accident _____ AM / PM

Please Describe the accident in your own words _____

_____

_____

_____

Were you the: ف Driver ف Front Passenger
ف Rear Passenger ف Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City / State _____

Nearest Intersection _____

Diving Condition: فDry فWet فIcy ف _____

Which Direction were you heading? _____

Speed you were traveling? _____

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VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐Yes ☐No

If yes, which type? ☐Lap ☐Shoulder

Was vehicle equipped with airbags? ☐Yes ☐No

If yes, did it/they inflate properly? ☐Yes ☐No

Did your seat have a headrest? ☐Yes ☐No

If yes, what was the position of the headrest?

☐Low ☐Midposition ☐High

OTHER VEHICLES
(if applicable)

Make and model of other vehicle _____

Direction other vehicle was heading _____

Speed of the other vehicle _____

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 ☐ _____

At 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? ☐Left ☐Right

Was your foot on the brake? ☐Yes ☐No

If yes, which foot was on the brake? ☐Left ☐Right

Were you: ☐Surprised by impact ☐Braced for impact

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? _____

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PATIENT CONDITION

Were you unconscious immediately after the accident? ف Yes ف No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

TREATMENT

Did you go to the hospital? ف Yes ف No

When did you go? ف Immediately after accident ف Next day ف 2 or more days after accident

How did you get to the hospital? ف Ambulance ف Private transportation

Name of Hospital _____ Name of Doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

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SYMPTOMS / INJURIES

Have you been able to work since this injury? ☐Yes ☐No How many days have you missed? _____

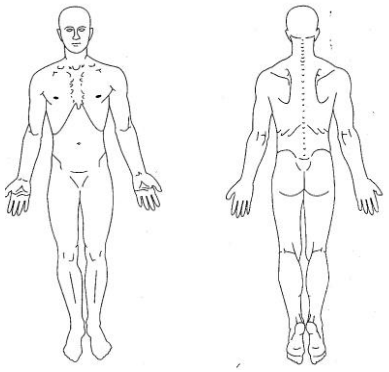
Prior to the injury were you able to work on an equal basis with others your age? ☐Yes ☐No

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

☐ Arm / Shoulder pain ☐ Feet / Toe numbness ☐ Neck pain
☐ Back pain ☐ Hand / finger pain ☐ Neck stiff ☐ Back stiffness ☐ Headaches ☐ Shortness of breath ☐ Chest pain
☐ Irritability ☐ Sleep difficulty ☐ Dizziness
☐ Jaw problems ☐ Stomach upset ☐ Ear buzzing
☐ Leg pain ☐ Tension ☐ Ear ringing
☐ Memory loss ☐ Vision blurred ☐ Fatigue ☐ Nausea

Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



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 ☐ _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down ☐ _____

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

Patient Signature _____ Date _____