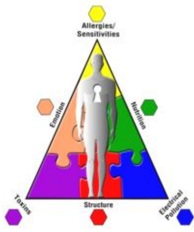

CASCADE CHIROPRACTIC

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AUTOMOBILE ACCIDENT HISTORY FORM

Date: ___________________________ Name: ____
Address: ____
City of accident: ____ State: ____________________________________
Please describe, to the best of you knowledge, what happened during the accident: ____________________________
____
____
____
Other driver's insurance company: _________________________________ Policy #: __________________________
Your Insurance Company: _____________________________________ Claim #: ______________________________
Agents name: ______________________ Have you retained an attorney? yes / no Name: _______________________
Road conditions at the time of the accident: Wet Dry Icy Other:____
Were the police called to the accident? yes / no Is there a report? yes / no
Did you go to the hospital? yes / no If yes, where: ____

How did you get to the hospital? ____
What parts of your body were x-rayed? ____
What did the hospital do for your injuries? ____
How long did you stay in the hospital? ____

What bleeding, if any, did you sustain during the accident? ____
What bruises, if any, did you sustain during the accident? ____
Where were you seated in the vehicle? ____
Were you aware of the approaching collision prior to impact, or were you caught by surprise? Aware / Surprise
Did you lose consciousness (black out) upon Impact? yes / no; if yes, how long? ______________________________
Did you experience a flash of light or explosion in your head? yes / no
Did you experience any of the following from the accident (please circle):

CONFUSED DISORIENTED LIGHT HEADED DIZZY
NAUSEATED BLURRED VISION RINGING/BUZZING IN EARS

If you are still having any of these symptoms, which ones: ____
Are you currently suffering from any of the following (please circle):

RESTLESSNESS IRRITABLE SLEEPLESSNESS FORGETFULLNESS
DIFFICULTY CONCENTRATING DIFFICULTY WITH MEMORY
REDUCED TOLLERANCE TO HEAT REDUCED TOLLARANCE TO COLD
Other: ____

How far is the top of the headrest or seat back form the top of your head (approximately)?

_______inches above or below.

Were you wearing a seatbelt? yes / no

If yes, was it a lap seat belt: yes / no Shoulder/lap belt: yes / no

Did you receive any injury or bruises from the seat belt? yes / no

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

Year: __________ Make: __________________________ Model: ________________________________

What was 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 the approximate speed? ___________mph.

If the other vehicle was moving at the time of the collision, was it:

Slowing down: yes / no

Gaining speed: yes / no

Traveling at a steady rate of speed: yes / no

What is the estimated cost of the damage done to the vehicle you were in? __________________________________

Was 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 at the time of the collision? yes / no

If no, what direction was it turned and by how much?____

On what part of the automobile did your following body parts hit:

Head: ___________________________________ Chest: ____

Right/left shoulder: ________________________ Right/left arm: __________________________________

Right/left hip: _____________________________ Right/left leg: __________________________________

Right/left knee: ____________________________ Other: ____

Have you lost time from work as a result of this accident? yes / no

Do you notice any restrictions as a result of this accident? yes / no

If yes, please describe: ____

____

Have you been involved in an accident prior to this? yes / no

If yes, please describe, including dates, type or types of accidents or injuries.: _________________________

____

____

Patient's signature: ____