

Performance Chiropractic
Vehicle Accident Information
PATIENT INFORMATION

Patient Name _____ Date _____

Date of Accident _____ Time of Accident _____ a.m. p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Year, make and model of vehicle you were in: _____

Were you wearing a seatbelt? Yes No

If yes, what type? Lap Shoulder

Did vehicle have airbags? Yes No

If yes, did it/they inflate? Yes No

Did your seat have a headrest? Yes No

If yes, what was the position of the headrest?

Low Midposition High

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

Which direction was the other vehicle headed? _____

Speed other vehicle was traveling _____

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? Right Left

Was your foot on the brake? Yes No

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

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? _____

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 _____

Were x-rays taken? Yes No If yes, what type of x-ray was taken? (ie back, neck, etc.) _____

SYMPTOMS / INJURIES

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

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

Please place a check before any of the symptoms below that you have had since your injury:

- | | | |
|--|---|---|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Pins and needles in arm | <input type="checkbox"/> Leg/hip pain | <input type="checkbox"/> Feet/toe numbness |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Head feels heavy |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Jaw problems |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Fever | <input type="checkbox"/> Face flushed |
| <input type="checkbox"/> Upset stomach | <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Ear ringing |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other _____ |

Is this condition getting progressively worse? Yes No Unknown

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

Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramping Stiffness Swelling Other _____

How often do you have this pain? _____

Is it consistent 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 Other _____

INSURANCE INFORMATION

Name of your insurance company involved: _____

Contact person _____ Contact number _____

Name of insurance company of person responsible for injuries: _____

Is there a case/claim number assigned to your accident? Yes No If yes, please provide the claim # _____

Do you have an attorney who has advised you in this case? Yes No If yes, please provide the following:

Name _____ Phone Number _____

Address _____

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

Patient Signature _____ Date _____