VERNONIA
CHIROPRACTIC CLINIC, INC.

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AUTO ACCIDENT FORM

Patient Name _____ Today's Date _____/_____/_____

What are your current symptoms? ❑ Pain ❑ Numbness ❑ Stiffness ❑ Weakness

Date of Accident: _____/_____/_____

Patient was located: ❑ Driver ❑ Passenger–middle front ❑ Passenger–right front ❑ Pedestrian ❑ Passenger–left rear ❑ Passenger–middle rear ❑ Passenger–right rear

Patient Vehicle Type: ❑ Compact ❑ Mid-size ❑ Full-Size ❑ SUV ❑ Pick-up ❑ Semi-truck ❑ Motorcycle ❑ Bicycle ❑ Other_____

Other Vehicle Type: ❑ Compact ❑ Mid-size ❑ Full-Size ❑ SUV ❑ Pick-up ❑ Motorcycle ❑ Semi-truck ❑ Other_____

Road Conditions: ❑ Clear ❑ Dark ❑ Dry ❑ Foggy ❑ Icy ❑ Snowy ❑ Wet

Road Type: ❑ Asphalt ❑ Concrete ❑ Dirt ❑ Gravel

Were you aware the accident was going to occur? ❑ Yes ❑ No

Were you wearing a seatbelt? ❑ Yes ❑ No And shoulder harness? ❑ Yes ❑ No

Did your airbag deploy? ❑ Yes ❑ No

Does your car have a head rest? ❑ Yes ❑ No

What position was the head rest in? ❑ Up ❑ Middle ❑ Down

Patient's Head Position: ❑ Looking Straight Ahead ❑ Left Level ❑ Left Up ❑ Left Down ❑ Right Level ❑ Right Up ❑ Right Down ❑ Looking Up ❑ Looking Down

ACCIDENT DETAILS

Was your car moving? ❑ Yes ❑ No

What was the vehicle you were in doing?

Vehicle stopped for: ❑ Traffic Light ❑ Intersection ❑ Stop Sign ❑ Traffic ❑ Pedestrian ❑ Parked

Vehicle slowing for: ❑ Traffic Light ❑ Intersection ❑ Stop Sign ❑ Traffic ❑ Pedestrian ❑ Parked

Vehicle moving: ❑ Slowly ❑ Moderately ❑ Fast

Was the other vehicle braking? ❑ Yes ❑ No Was the other vehicle moving? ❑ Yes ❑ No

Collision Details: ❑ hit by other vehicle ❑ hit other vehicle ❑ hit by object ❑ hit object

Impact Location: ❑ front ❑ front-right ❑ front-left ❑ left ❑ right ❑ right-rear ❑ left-rear ❑ rear ❑ top

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Have you seen any other doctors since your motor vehicle collision? ❑ Yes ❑ No.

If yes, whom and what type of treatment was provided: _____

_____

HOSPITALIZED

Did you go to the hospital? ❑ Yes ❑ No. If yes, please answer the questions below:

When were you hospitalized? ❑ immediately ❑ later same day ❑ next day ❑ date _____

How were you transported to the hospital? ❑ ambulance ❑ life flight ❑ private transportation

What did the hospital recommend? ❑ no instructions ❑ see physical therapist ❑ see Chiropractor
❑ see own doctor ❑ see orthopedist ❑ see neurologist ❑ prescription medication
❑ heat ❑ ice ❑ rest ❑ other:_____

Did you have any x-rays taken? ❑ Yes ❑ No If yes, what areas? _____

_____

SUMMARY OF ACCIDENT

_____

_____

_____

_____

_____