Westerville
CHIROPRACTIC & NUTRITION
ENROLL. EMPOWER. TRANSFORM.

Vehicle Accident Information

Patient Information:

Patient Name_____ Date_____
Date of Accident_____ Time of accident_____ AM PM

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 with road/street_____ Which direction were you headed?_____
Driving conditions ___Dry ___Wet ___Icy ___Other_____ Speed you were traveling?_____

Vehicle:

Make and model of vehicle you were in _____
Where 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 *What was it's position?* ___Low ___Midposition ___High

Impact:

Did your car impact another vehicle? ___Yes ___No Did your car impact a structure ___Yes ___No
Did any part of your body strike anything in the vehicle (explain)_____
Was impact from: ___Front ___Rear ___Left ___Right ___Other_____
At the time of impact were you:
___Looking up ___Looking down ___Looking straight ahead
___Looking to the right ___Looking to the Left
Were both hands on the steering wheel? ___Yes ___No Only one hand on the wheel ___R ___L
Was your foot on the brake? ___Yes ___No *If YES, which food was on the brake?* ___*R* ___*L*
Were you: ___Surprised by the impact ___Braced for the impact

Police:

Police called and on site? ___Yes ___No
Was a report filed? ___Yes ___No
Were there any witnesses? ___Yes ___No
Was a traffic violation issued? ___Yes ___No
If Yes, to whom? _____

Other Vehicle:

Make and model of other vehicle_____
_____
Direction other vehicle was heading_____
Speed traveling_____

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Patient Condition:

Were you unconscious immediately after the accident? ___Yes ___No *For how long?*_____
Please describe how you felt immediately after the accident:_____
_____

Treatment:

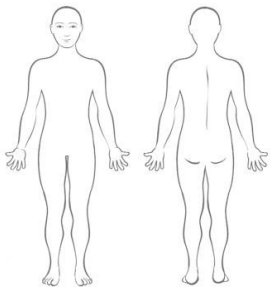
Did you go to the hospital? ___Yes ___No How did you get there? ___Ambulance __Other
When did you go? ___Immediately after accident ___Next day ___2 days or more after the accident
Name of hospital _____ Name of doctor_____
Diagnosis_____
Treatment received_____
X-rays taken_____

Symptoms/Injuries:

Have you been able to work since this injury? ___Yes ___No # of 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 numbness	☐Neck stiff
☐Back stiffness	☐Headaches	☐Shortness of breath
☐Chest pain	☐Irritability	☐Sleep difficulty
☐Dizziness	☐Jaw problems	☐Stomach upset
☐Ear bussing	☐Leg pain	☐Tension
☐Ear ringing	☐Memory loss	☐Vision blurred
	☐Nausea	☐Fatigue

Is this condition getting progressively 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: ___Cramps ___Swelling ___Stiffness
___Sharp ___Dull ___Throbbing ___Numbness
___Aching ___Shooting ___Burning ___Tingling



How often do you have this pain?_____
Is it constant or does it come and go?_____

Does it interfere with your : ___Work ___Sleep ___Daily Routing ___Recreation
Movements that are painful to perform: ___Sit ___Stand ___Walk ___Bending ___Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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