WESTERVILLE
CHIROPRACTIC & NUTRITION

Vehicle Accident Info.

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__________________________

Patient Condition:

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

Treatment:

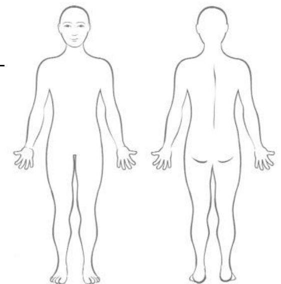
Did you go to the hospital? ___Yes ___No How did you get there? ___Ambulance __Other
When did you go? ___Immediately after accident ___Next day ___2 days or more after the accident
Name of hospital ______________________________ Name of doctor___________________________
Diagnosis____
Treatment received____
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