

# Arizona Chiropractic Center Automobile Accident History

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Date Of Accident \_\_\_\_\_

The speed of your vehicle was:  Stopped  Accelerating  Constant  Slowing \_\_\_\_\_ mph

What Was The Other Vehicle's Speed At Impact?  Stopped  \_\_\_\_\_ mph

Head Restraints:  None  Built into seats  In the up position  In the down position  Don't know

Where Was Your Car Struck?  Front  Rear  R-Side  L-Side  R-Front Corner  
 L-Front Corner  R-Back Corner  L-Back Corner  Roll -over  Other \_\_\_\_\_

Your Position In The Car Was?  Driver  Front right passenger  Back left passenger  Back right passenger

Your Vehicle Was A?  Subcompact  Compact  Mid-Size Car  Full Size Car  
 Small SUV  Mid-Size SUV  Large SUV  Minivan  Full Size Van  
 Wagon  Small Truck  Full Size Truck  Delivery Truck  Tractor Trailor  
 Other \_\_\_\_\_

Other Vehicle Was A?  Subcompact  Compact  Mid-Size Car  Full Size Car  
 Small SUV  Mid-Size SUV  Large SUV  Minivan  Full Size Van  
 Wagon  Small Truck  Full Size Truck  Delivery Truck  Tractor Trailor  
 Other \_\_\_\_\_

Time of Day:  Daylight  Dawn  Dusk  Dark

Road Conditions:  Dry  Damp  Wet  Snow-Covered  Icy

Were You Wearing Your Seatbelt At The Time Of Impact?  Yes  No  Unknown

Were The Brakes Applied At The Time Of Impact?  Yes  No  Unknown

Did The Airbags Deploy At The Time Of Impact?  Yes  No  Unknown

Did The Seat Break At The Time Of Impact?  Yes  No  Unknown

Were Your Hands On The Steering Wheel?  Both Hands  Left Hand  Right Hand  Can't recall

Head Apparel:  Knocked Off  Hat  Glasses  Both  Neither

Location Of Accident \_\_\_\_\_

Body Position at Impact:  Upright  Leaning Forward  Turned Left  Turned Right  Can't Recall

Head Position At Impact:  Not Turned  Turned Left  Turned Right  Can't Recall

**We You Aware That Accident Was Going To Occur?:**     Yes                     No

**Did Your Body Hit Anything Inside The Vehicle?**     Steering Wheel             Dashboard  
 Windshield     Side Door                     Arm Rests             Side Window             Other

**What Part Of Your Body Hit The Above Part In Your Car?**     Head             Chest             Chin  
 Knee             Shoulder             Hand             Other \_\_\_\_\_

**Where Did You Go After The Accident?**     Hospital             Chiropractor             Family Doctor  
 Home     Work             Other

**Did You Lose Consciousness?**     Yes             No

**Police At Crash Site:**     No Police On-Scene     Police On Scene And Report Was Made     Police On Scene But No Report Was Made     Can't Remember

**Immediate Symptoms:**     Back Pain     Disorientation     Dizziness     Headache     Left/Right Arm Numbness  
 Left/Right Arm Pain     Nausea     Neck Pain     Left/Right Leg Numbness     Left/Right Leg Pain

**Estimated Property Damage To Your Vehicle:** \_\_\_\_\_

**Estimated Property Damage To Other Vehicle:** \_\_\_\_\_

**In Detail, Describe How The Accident Occurred:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Were You Admitted To The Hospital?**     Yes    Date Admitted: \_\_\_\_\_ **Duration Of Stay?** \_\_\_\_\_     No

**If You Went To The Hospital, When?**             At The Time Of The Accident             Next Day

**How Did You Get To The Hospital?**     Ambulance             Police Car             Private Transportation

**Name Of Hospital, or Physician:** \_\_\_\_\_

**What Treatment Was Given?**                     None             Placed In A Cervical Collar             X-Rayed  
 Given Pain Medication     Given Instructions Regarding Concussions / Sprains-Strains  
 Stitches / Bandaged             Physical Therapy             Referred To This Office For Treatment  
 Instructed To Call An Orthopedic Surgeon / Private Physician  
 Other \_\_\_\_\_

**Immediately After The Accident Were You In Pain?**     Yes             No

**If You Were In Pain, What Part Of The Body Hurt?**

- Headache       Head       Neck  
 TMJ(jaw)    Shoulder    Upper Back    Mid Back       Ribs       Arm  
 Low Back       Hip       Leg       Foot       Ankle       Other\_\_\_\_\_

**Please Describe The Pain:** Achey      Burning      Dull      Numb      Sharp      Shooting      Sore  
Stiff      Tingling

**Have You Experienced These Symptoms Before This Accident?**    Yes       No       Similar

**If Yes, When?** \_\_\_\_\_

**After The Accident How Did You Feel?**       Dizzy / Dazed       Disoriented       Unconscious  
 Nervous       Nauseous       Upset       Weak       Other

**If You Were Not Immediately In Pain, When Did Symptoms First Begin?**

\_\_\_\_\_

**Have You Seen Any Other Doctor Or Had Any Diagnostic Tests As A Result Of This Accident?**  Yes

No      Tests:  MRI       EMG       X-rays      **Doctor's Name:** \_\_\_\_\_

**Have You Lost Any Time From Work Due To This Accident?**  Yes    No      From \_\_\_\_\_ To \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_