AUTO ACCIDENT HISTORY

Patient's Name: Date of Accident:

Your location in the vehicle: (Driver) (Passenger) (Front Seat) (Back Seat)

Others in the vehicle: (Yes) (No)

Side of impact: (front) (rear) (drivers side) (passenger side)

Please describe the accident in detail:

Road Conditions: (Wet) (Dry) (Icy)

Did you see the accident coming? (Yes) (No)

Were you wearing a seatbelt? (Yes) (No) Shoulder harness: (Yes) (No)

Type of vehicle you were in? Year: Make: Model:

Distance your car was pushed: Speed Of your car: Speed of other car:

Did you hit the inside of the car with your body? (Yes) (No)
If yes, what did you hit?

Were you knocked unconscious? (Yes) (No) (Unsure)

Please list the symptoms you had right away:

Please list the symptoms you experienced later:

Are you: (Staying the same) or (Getting worse)

Did you go to the Hospital or see a Doctor before coming here? (Yes) (No)

Hospital or doctor name? Were you transported by ambulance? (Yes) (No)

Date of previous motor vehicle accident? Previous Chiropractic care?

Are you employed? (Yes) (No) If so where?

Did you miss any time from work? (Yes) (No) How much time?