HAVEN CHIROPRACTIC CENTER
301 Columbia Street, Schuylkill Haven, PA 17972
Automobile Accident Information

Patient Number_____
(for office use only)

PATIENT INFORMATION

Name_____ Date_____
Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.
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

Street Name_____
City/State_____
Nearest Intersection with street_____
Driving Conditions ☐ Dry ☐ Wet ☐ Icy ☐Other_____

Vehicle

1. Make and model of vehicle you were in:
_____
2. Were you wearing a seat belt? ☐ Yes ☐ No
a. If yes, what type? ☐ Shoulder ☐ Lap
3. Was your vehicle equipped with airbags? ☐ Yes ☐ No
a. If yes, did they inflate properly? ☐ Yes ☐ No
4. Did your seat have a head rest? ☐ Yes ☐ No
a. If yes, what was the position of the headrest?
☐ Low ☐ Midposition ☐ High

Other Vehicle

1. Make and model of other vehicle_____
2. Which direction was other vehicle headed? _____
3. Speed other vehicle was traveling _____

Police

1. Did the police come to the accident site? ☐ Yes ☐ No
2. Were there any witnesses ☐ Yes ☐ No
3. Was a police report filed? ☐ Yes ☐ No
4. Was a traffic violation issued? ☐ Yes ☐ No
If yes, to whom?_____

Impact

1. What was the vehicle you were in doing? Answer ONE of the following (a-d)
a. Vehicle stopped for:
☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic
☐ Pedestrian ☐ Parked
☐ Other_____
b. Vehicle slowing down for:
☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic
☐ Pedestrian ☐ Parked
☐ Other_____
c. Vehicle Moving:
☐ Slowly ☐ Moderately ☐ Fast
_____ MPH (if known)
d. Vehicle doing other:
_____
2. Did your car impact another vehicle? ☐ Yes ☐ No
3. Did your car impact a structure? ☐ Yes ☐ No
4. Was impact from:
☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____
5. What damage did your vehicle sustain?
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
6. Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If yes, explain_____
_____
7. At the time of impact were you:
☐ Looking straight ahead ☐ Looking right
☐ Looking left ☐ Looking down
☐ Looking up ☐ Unsure
8. Were both hands on the steering wheel?
☐ Yes ☐ No
a. If no, which hand was on the wheel? ☐ RH ☐ LH
9. Was your foot on the brake? ☐ Yes ☐ No
If yes, which foot was on the brake? ☐ RF ☐ LF
10. Were you:
☐ Surprised by impact ☐ Braced for impact

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Patient Condition

1. Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? _____
2. Please describe how you felt immediately after the accident:

_____

_____

Treatment

1. Did you go to the hospital? ☐ Yes ☐ No
2. When did you go? ☐ Immediately after the accident ☐ Next Day ☐ 2 days or more after the accident
3. How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of Hospital_____ Name of Doctor_____

Diagnosis (if known)_____

Treatment Received_____

Xrays Taken? ☐ Yes ☐ No If yes, date? _____

In what part of body were Xrays taken?_____

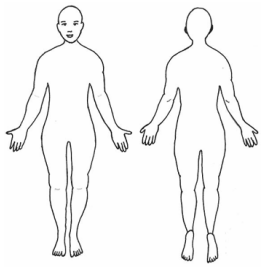
Symptoms/Injuries

1. Have you been able to work since the injury? ☐ Yes ☐ No How many work days have you missed?_____
2. Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No
3. If you have had any of the following symptoms since your injury, please check the corresponding 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 buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	☐ Other_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unsure

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 0 (no pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movement(s) that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

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

Patient signature_____ Date_____