JOSHUA SPINE + HEALTH CENTER
CHIROPRACTIC • MASSAGE • WELLNESS

Automobile Accident History Form

Today's Date: _____

Patient Information

Name: _____

Date of Accident: _____ Time of Accident: _____

Please describe the accident in your own words: _____

_____

Were you the: □ Driver □Front Passenger □Rear Passenger □Pedestrian

How many people were in your vehicle? _____

Your Auto Insurance Company: _____Claim #: _____

Insurance Co. Phone #: _____Insured's Name: _____

Did you retain an attorney? ☐Yes ☐No If yes, name and phone #: _____

Name of party who hit you: _____Other Party's Auto Insurance Co.: _____

Claim #: _____ Insurance Co. Phone #: _____

Insured's Name: _____

Accident Site

Road/Street Name: _____ City/State: _____

Nearest Intersection _____ Driving Conditions: ☐Dry ☐Wet ☐Icy ☐Other_____

Speed you were traveling: _____ Other Vehicles Speed: _____Direction were you heading?_____

Vehicle

Make and Model of vehicle you were in: _____

Were you wearing a seatbelt? ☐Yes ☐No If yes, what type? ☐Lap ☐Shoulder

Did the airbag deploy? ☐Yes ☐No What is the estimated cost of damage to your vehicle? _____

Did you have a headrest? ☐Yes ☐No If so, what position was it in? ☐Low ☐Midposition ☐High

Make and Model of other vehicle: _____ Direction it was headed: _____

Impact

Did your car impact another vehicle? ☐Yes ☐No Did your car impact a structure? ☐Yes ☐No

If yes, please explain: _____

Did any part of your body strike anything in the vehicle? ☐Yes ☐No If yes, explain: _____

Was the impact from: ☐Front ☐Rear ☐Left ☐Right ☐Other _____

At the time of impact, were you: ☐Looking straight ☐Looking up ☐Looking down ☐Looking L ☐Looking R

Were both hands on steering wheel? ☐Yes ☐No If no, which hand was? ☐Left ☐Right ☐None

Were you: ☐Surprised by impact ☐Braced for impact

Police

Did the police come to the accident site? □Yes □No Was a police report filed? □Yes □No

Was a traffic violation issued? □Yes □No If yes, to whom? _____

Were there any witnesses? □Yes □No

Patient Condition

Were you unconscious immediately after the accident? □Yes □No If yes, how long? _____

Please describe how you felt immediately after the accident: _____

_____

Treatment

Did you go to the hospital? □Yes □No

If yes when did you go? □Immediately after the accident □Next day □2 or more days after the accident

How did you go to the hospital? □Ambulance □Private transportation

Name of hospital: _____ City: _____

Diagnosis: _____

Treatment Received: _____

X-Rays taken: _____

Symptoms/Injuries

Have you been able to work since this injury? □Yes □No Number of days missed: _____

Prior to the injury, were you able to work on an equal basis with others your age? □Yes □No

Check below if you have had any of the following since the injury:

□Arm/Shoulder Pain	□Feet/Toe Numbness	□Neck Pain	□Back Pain
□Hand/Finger numbness	□Neck stiff	□Back stiffness/soreness	□Headaches
□Shortness of breath	□Chest pain	□Irritability	□Difficulty Sleeping
□Dizziness	□Jaw problems	□Stomach upset	□Ear buzzing/ringing
□Leg Pain	□Hip Pain	□Memory Loss	□Blurry Vision
□Fatigue	□Nausea	□Stress	

Is this condition getting progressively worse? Yes No

Rate the severity of your condition on a scale of 1 to 10 (10 being the worse) _____

Type of pain: □Sharp □Throbbing □Numbness □Aching □Shooting □Burning
□Dull □Tingling □Stiffness □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

Activities or movements that are painful to perform: □Sitting □Standing □Walking □Bending
□Lying down □Lifting □Turning head

I certify that the above information is correct to the best of my knowledge:

Patient/Guardian Signature: _____