Askeland Chiropractic & Acupuncture

AUTOMOBILE ACCIDENT HISTORY

Name_____Address_____

Sex:____ Age:____ Driver's License #:_____

General Symptoms:

Did you hit any part of your body during the collision (head or chest on steering wheel or dash board?____ If Yes, which part and how?_____

_____

Did you become/have: **Confused** **Disoriented** **Light-Headed** **Dizzy** **Nauseous** **Blurred Vision** **Ringing in the ears**

Do you still have any symptoms?_____ Which ones?_____

Are you currently suffering from any of the following?
Restlessness **Irritability** **Poor Concentration** **Memory Loss** **Insomnia**

Did you go to a hospital?_____ If Yes, which hospital?_____
How did you get to the hospital?_____
What parts of your body were x-rayed at thehospital?_____
What did the hospital do for your injuries?_____
Were you bleeding at the time of the accident?_____
What bruises did you sustain during this accident?_____
Did you receive care from any other medical professional?_____ Name?_____
What type of care were you given and for how long?_____
Where did you feel the pain?_____
What are your current symptoms?_____
Have you ever been injured in a similar manner?_____ If Yes, how and when?_____
_____

Accident History:

Date:_____ Time:_____
State how the accident happened in your own words:_____
_____
_____

Were you Driving? **Yes** **No** Were you a passenger in the: **Front** or **Back**
Were you on the: **Right Side** or **Left Side**
Were you looking straight ahead? **Yes** **No** If No, then where were you looking?_____
Was it your car? **Yes** **No** If Not, Whose? _____

Other People in car: Name and Address:
1)_____ Address_____
2)_____ Address _____
3)_____ Address _____

Was your car stopped at the time of impact? **Yes No**
If Yes, was the driver's foot also on the brake? Yes No
If No, then estimate the speed of the vehicle you were in: mph

If your vehicle was moving at the time of impact, was it:
slowing down? **Yes No** Accelerating? **Yes No**
traveling at a steady rate of speed? **Yes No**

Were you wearing a seat belt? **Yes No** Was the shoulder harness on? **Yes No**
Did you receive any injury or bruise from the seat belt? **Yes No**
If yes, then describe the injury:_____

How far is the top of the headrest or reattack from the top of your head:_____inches above or below

Was it: **Daylight Night Dusk Dawn**
Were you tired? **Yes No** Were you awake? **Yes No**
How long had you been in the car?_____
Where were you prior to the accident?_____
What were the weather conditions?_____
What was the posted speed limit?_____ mph How fast were you going? mph_____

Type of road? **Two Lane Four Lane Gravel Tar**
Did the collision occur at **a stop sign**?_____**a traffic light**?_____**an intersection**?____
Which area of your car was damaged? **Front Back Left Side Right Side**

What damage was done to your car?
Inside:_____
Outside:_____
Other:_____

Was the other vehicle moving during the collision?____ Approximate speed?_____ mph
If the other vehicle was moving at the time of the collision, was it:
Slowing Down Accelerating Traveling at a steady speed

Was the damage to the other car? **Yes No**
Inside:_____
Outside:_____

What type of vehicle were you driving? Make:_____ Model:_____ Year:_____
What condition was your car in prior to the accident?_____
Do you have pictures of the involved automobile? **Yes No**

What is the estimated cost damage to the vehicle you were in? $_____

Which of the following parts of your vehicle were damaged during the accident?
Windshield Right/Left Side Window Steering Wheel
Other_____

What other type of vehicle was involved in the accident? **Car Truck Motorcycle**
Size and type:_____

Was a police report filed? **Yes No** By Police of: **City County State**
Who was ticketed?_____
For what?_____

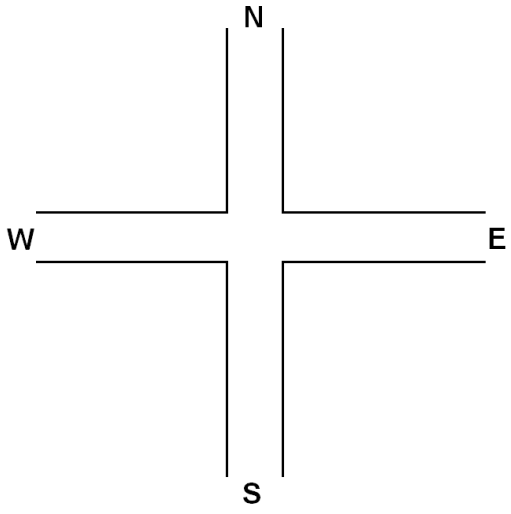
Did your vehicle strike anything else? **Yes No**
If Yes, what? **Another Car a Sign a Tree a Bridge Other** _____

Did you lose consciousness (black out) on impact? **Yes No** How long?_____
Did you experience a flash of light or explosion in your head? **Yes No**
Do you remember the impact? **Yes No**
Were you aware of the approaching collision prior to impact? **Yes No**

Did your vehicle go off the road? **Yes No**
If so: **Into an Embankment a Ditch** How Deep?_____
Does it bother you to ride in a car now? **Yes No** If so, as a: **Driver Passenger**

Have you had any time loss from work? **Yes No**
Have you had any outside help? **Yes No**

Please Draw the Accident:



Patient Signature_____Date_____