SALINA
CHIROPRACTIC

VEHICLE ACCIDENT INFORMATION

Patient Name_____ **Date**_____

Date of Accident _____ **Time of Accident** _____ **am pm**

Please describe the accident in your own words:

_____
_____
_____
_____

Were you: ___ driver ___ front seat passenger ___rear seat passenger ___ pedestrian

How many people were in the car? _____

Accident Site_____ City _____ State_____

Speed of your vehicle at time of accident ____ **Make and model of your vehicle**_____

Were you wearing a seat belt? Yes No **Did your airbag deploy?** Yes No

Was impact from: __ behind ___front ___ driver side ___ passenger side ___ other - _____
_

Did your car impact another vehicle? Yes No **Did your car impact another structure?** Yes No

Did your body strike anything in the vehicle? Yes No – If yes, please describe _____

Other vehicle make and model _____ **Estimated speed** _____

At time of impact were you: ___ looking straight ahead ___ looking to left ___ looking to right
___ looking up ___ looking down

Were both hands on the wheel? Yes No **If no, which hand was on the wheel?** Left Right

Was your foot on the break? Yes No **If yes, which foot?** Left Right

Were you? ____ Surprised by impact ____ braced for impact

Did the police come to the accident scene? Yes No **If yes, was a police report filed?** Yes No

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

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

Please describe how you felt immediately after the accident? _____
_____
_____
_____
_____

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Did you go to the hospital? Yes No **If yes, when and what was done / what was recommended?**

_____

_____

_____

Name of Hospital _____ X-rays taken? Yes No
Diagnosis _____ Doctor Name _____

Have you been able to work since the accident? Yes No – If no, describe

_____

What symptoms do you have now? _____

Is pain constant or does it come and go? _____

On a scale of 1-10 with 1 being no pain and 10 being severe pain what is your current pain level? _____

Does pain interfere with your: __ work __ sleep __ daily routine __recreation

Movements that are painful to perform: __ sitting __ standing __ lying down __ bending __walking

Please provide any additional information you feel is important to provide:

Signature of Patient_____ **Date** _____

Guardian Signature (if applicable) _____ **Date**_____