Arrowhead HEALTH CENTERS

AUTO ACCIDENT HISTORY

Dear Patient, ***Internal Form Only***

We are asking for this information because we care about your health and your answers will help us determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond positively, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

PLEASE ANSWER ALL QUESTIONS COMPLETELY (*Please check boxes and fill in all blank areas)*

Patient Name: _____ Date of Accident: _____

1. Do you have a lawyer? ❑ Yes ❑ No
2. Was the accident on the job? ❑ Yes ❑ No
3. Your estimated speed at the moment of impact: ❑ Full Stop ❑ Slowing ❑ Speeding up ❑ Normal posted speed
4. Did your vehicle strike any other car or object (s) after the crash? ❑ Yes ❑ No, Object: _____
5. What was the time of day? ❑ Daylight ❑ Dawn ❑ Dusk ❑ Dark
6. What were the road conditions? ❑ Dry ❑ Damp ❑ Wet ❑ Snow ❑ Ice ❑ Other: _____
7. Where the police notified? ❑ Yes ❑ No
8. Were you struck from: ❑ Behind ❑ Front ❑ Driver's side ❑ Passenger's side ❑ Other: _____
9. Were you the: ❑ Driver ❑ Front seat passenger ❑ Back seat passenger ❑ Other: _____
10. What type of vehicle were you in? _____
11. What type of vehicle struck you? _____
12. Were restraints used? ❑ Yes ❑ No, Type: ❑ Lap & Shoulder ❑ Lap only ❑ Car seat ❑ Other: _____
13. Your body position: ❑ Facing forward ❑ Turned left ❑ Turned right ❑ Leaning forward ❑ Other: _____
14. Head position: ❑ Facing forward ❑ Turned left ❑ Turned right ❑ Up ❑ Down
15. Were brakes applied at impact? ❑ Yes ❑ No ❑ N/A
16. Were you aware of impending crash? ❑ Yes ❑ No
17. Did your air bag deploy? ❑ Yes ❑ No
18. If your air bag did deploy, were you struck by the air bag? ❑ Yes ❑ No ❑ N/A
19. Did you incur any burns? ❑ Yes ❑ No, Where? _____
20. Did your body strike anything in the vehicle? ❑ Yes ❑ No If yes, what? _____
21. Were you wearing a hat or glasses? ❑ Yes ❑ No If yes, were they still on after the crash? ❑ Yes ❑ No
22. Where did you feel pain immediately after the accident? _____
23. Were you knocked unconscious? ❑ Yes ❑ No If yes, for how long? _____
24. Where did you go after the accident? ❑ Home ❑ Work ❑ Hospital: _____ ❑Other:_____
25. How did you get there? ❑ Own car ❑ Ambulance ❑ Other _____
26. What treatment was given/prescribed at the hosp/ Dr's office: ❑ pain medication ❑ X-ray (area) _____
    ❑ Other: _____
27. Did you receive any stitches for any cuts at the hospital? ❑ Yes ❑ No If yes, where: _____
28. Did you have any contusions or abrasions? ❑ Yes ❑ No If yes, where: _____
29. Have you missed work due to the accident? ❑ Yes ❑ No If yes, how much? _____
30. Since this injury, are your symptoms: ❑ Improving ❑ Getting worse ❑ About the Same

Description of Accident (Other Side) →

Arrowhead HEALTH CENTERS

AUTO ACCIDENT HISTORY

31. Where did the collision occur on your vehicle? ❑ Rear ❑ Front ❑ Driver Side ❑ Passenger Side ❑ Rollover
32. Where did the collision occur on the other vehicle? ❑ Rear ❑ Front ❑ Driver Side ❑ Passenger Side ❑ Rollover
33. Describe the damage to your vehicle: ❑ Minimal ❑ Moderate ❑ Extensive ❑ Total
34. Describe the damage on the other vehicle: ❑ Minimal ❑ Moderate ❑ Extensive ❑ Total
35. What speed was your vehicle moving at the time of the accident? ❑ Stopped ❑ Slow ❑ Moderate ❑ High
36. What speed was the other vehicle moving at the time of the accident? ❑ Stopped ❑ Slow ❑ Moderate ❑ High
37. Describe what happened (location, how the accident occurred, etc.):