

Be Truly Well Chiropractic & Day Spa

Vehicle Accident Information

Patient Information

Name _____ Date _____ Patient _____
 Date of Accident _____ Time of Accident _____ am pm Please describe the accident in your own words:

Were you the: Driver Front Passenger Rear Passenger Pedestrian How many vehicles were in the accident? _____ How many people were in the accident? _____ Were you unconscious after the accident? Yes No Did you go to the hospital? Yes No When did you go? Immediately Next Day 2 days or more after the accident Did you stay overnight? Yes No How did you get to the hospital? Ambulance Private Transportation Other _____ Name of hospital? _____ Name of doctor? _____
 Diagnosis? _____ What medication(s) were you prescribed? _____ What X-ray/MRI/Special Image(s) were taken _____ Treatment received (i.e. stitches, braces, etc.) _____

Accident Details

Road/Street Name & City/State _____
 Which direction were you headed _____ What speed you were traveling? _____ Unknown Did your car impact another vehicle? Yes No Did your car impact a structure? Yes No If yes, explain _____ Did any part of your body strike anything in the vehicle? Yes No If yes, explain _____ Was impact from: Front Rear Left Right Other _____ At the time of impact were you: Looking straight ahead Looking to the right

- Looking to the left Looking down Looking up Was your torso: Forward Left Right Flexed Extended Other _____ Where were your hands positioned? Both on the wheel Right on the wheel
- Left on the wheel On the ceiling On the dashboard At your sides

Was your foot on the brake? Yes No
 If yes, which foot was on the brake? Left Right
 Were you: Surprised by impact Braced for impact
 Was a police report filed? Yes No

Vehicle

What type of vehicle were you in? Compact Mid-size SUV Truck
Was your car: Slowing down Stopped Gaining speed At a steady speed
Were you wearing seatbelts? Yes • No
If yes, what type? Lap Shoulder Both

Did you: Remain in your seatbelt Slide out of your seatbelt Partially slide out
What happened to your vehicle after the crash?(Ex: went straight, spun around, hit something) _____

What was damaged on/in your vehicle?(Be as descriptive as possible)_____

Did the vehicle have airbags? Yes No Did they inflate properly? Yes No Were the headrests:
 Movable and fixed Non-movable and fixed No headrest What was the position of the headrest?
 Low Midposition High N/A

Other Vehicle

What type was the other vehicle? Compact Mid-size SUV Truck Was your car:
 Slowing down Stopped Gaining speed At a steady speed Which direction was the other vehicle headed?
_____ What was their speed?
_____ Unknown

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

Signature of patient, parent, guardian or representative

Date

Please print name of patient, parent, guardian, or representative

Relationship to patient