Health Luminosity

Automobile Accident Description

Name _____
Address _____
City _____ Zip code _____ Preferred phone _____
☐ Male ☐ Female Age _____ Birth Date _____ E-mail _____
Date of Accident _____

Insurance Company _____ Phone _____
Claim # _____ Billing Address _____
Name of the Insured _____ Contact/Claim Agent _____

1. Your vehicle type
☐ Car ☐ Van ☐ Bus ☐ Station wagon ☐ Pickup truck ☐ Large truck Other _____
2. Your position in vehicle
☐ Driver ☐ Front passenger ☐ Left rear passenger ☐ Right rear passenger Other _____
3. What was your vehicle doing at the time of the accident?
☐ Stopped at intersection ☐ Making a left turn ☐ Proceeding along ☐ Slowing down
☐ Stopped at light ☐ Making a right turn ☐ Accelerating Other _____
☐ Stopped at traffic ☐ Parking
4. Time/speed
Time of accident _____ Your vehicle's speed _____ Other vehicle's speed _____
5. Details of accident
Visibility at time of accident
☐ Poor ☐ Fair ☐ Good
☐ You hit other vehicle ☐ Other vehicle hit you You hit … (object) _____
6. Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry
Point of Impact
☐ Head-on ☐ Right front
☐ Rear-end ☐ Right rear
☐ Left front ☐ Left rear
7. Body position, etc.
Did you see the accident coming? ☐ Yes ☐ No
Were you braced for the impact? ☐ Yes ☐ No
Does your vehicle have headrests? ☐ Yes ☐ No
Did you have a seat belt on? ☐ Yes ☐ No
Did you have a shoulder harness on? ☐ Yes ☐ No

What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

What was the direction of your head at the time of the impact?
☐ Facing straightforward ☐ Turned to the right ☐ Turned to the left

8. During the accident
Did your body strike the inside of your vehicle? ☐ Yes ☐ No
If yes, describe: _____
Did you lose consciousness during the injury? ☐ Yes ☐ No
If yes, for how long? _____
Damage to your vehicle ☐ Mild ☐ Moderate ☐ Totaled
Your vehicle's estimated damage? _____
Did police show up at the scene? ☐ Yes ☐ No
Was an accident report filled out? ☐ Yes ☐ No

9. After the accident

Check off your symptoms right after and a few days following:

☐ Headache	☐ Dizziness	☐ Middle back pain	☐ Cold hands	☐ Neck pain
☐ Nausea	☐ Low back pain	☐ Cold feet	☐ Neck stiffness	☐ Toe numbness
☐ Anxious	☐ Loss of smell	☐ Irritability	☐ Constipation	☐ Chest pain
☐ Pain behind eyes	☐ Shortness of breath	☐ Sleeping problems	☐ Confusion	☐ Nervousness
☐ Diarrhea	☐ Fainting	☐ Fatigue	☐ Loss of taste	☐ Depression
☐ Ringing in ears	☐ Tension	☐ Mid back pain		

Other _____

10. Treatment history

Where did you go after the accident?

☐ Home ☐ Work ☐ Hospital ER ☐ Private doctor

How did you get there?

☐ Drove self ☐ Somebody else

☐ Ambulance ☐ Police

Were x-rays taken? ☐ Yes ☐ No

Was lab work done? ☐ Yes ☐ No

Treatments

☐ Cervical collar ☐ Ice Other _____

Medications _____

Follow-up instructions _____

11. Fill in any other doctors seen prior to your first visit to this office

Name _____ First visit date _____

Specialty _____ Were x-rays taken ☐ Yes ☐ No

Types of treatments received _____

How many treatments received _____ Currently treating? ☐ Yes ☐ No

Did treatments benefit you? ☐ Yes ☐ No Last visit date _____

12. Additional accident information: Enter any additional information here that is not covered by the above checkoffs:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate chiropractic treatment.

Consent for Treatment

I voluntarily consent to the rendering of care including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending doctor and it is the responsibility of the staff to carry out the instructions of such doctor.

Signature of patient _____ Current Date _____

Signature of parent/guardian if patient is a minor _____ Current Date _____