

# VEHICLE ACCIDENT INFORMATION

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_  a.m.  p.m.

Please describe the accident in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian How many people were in the accident vehicle? \_\_\_\_\_

## ACCIDENT SITE

Road/Street Name \_\_\_\_\_  
City/State \_\_\_\_\_  
Nearest intersection with road/street \_\_\_\_\_  
Driving conditions  Dry  Wet  Icy  Other \_\_\_\_\_  
Which direction were you headed? \_\_\_\_\_  
Speed you were traveling? \_\_\_\_\_

## VEHICLE

Make and model of vehicle you were in: \_\_\_\_\_  
Were you wearing a seatbelt?  Yes  No  
If yes, what type?  Lap  Shoulder  
Was vehicle equipped with airbags?  Yes  No  
If yes, did it/they inflate properly?  Yes  No  
Did your seat have a headrest?  Yes  No  
If yes, what was the position of the headrest?  
 Low  Midposition  High

## OTHER VEHICLE

(if applicable)

Make and model of other vehicle \_\_\_\_\_  
Which direction was other vehicle headed? \_\_\_\_\_  
Speed other vehicle was traveling \_\_\_\_\_

## IMPACT

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  
Were both hands on the steering wheel?  Yes  No  
If no, which hand was on the wheel?  Right  Left  
Was your foot on the brake?  Yes  No  
If yes, which foot was on the brake?  Right  Left  
Were you:  Surprised by impact  Braced for impact

## POLICE

Did the police come to the accident site?  Yes  No  
Were there any witnesses?  Yes  No  
Was a police report filed?  Yes  No  
Was a traffic violation issued?  Yes  No  
If yes, to whom? \_\_\_\_\_

## PATIENT CONDITION

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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## TREATMENT

Did you go to the hospital?  Yes  No

When did you go?  Immediately after accident  Next day  2 days or more after the accident

How did you get to the hospital?  Ambulance  Private transportation

Name of hospital \_\_\_\_\_ Name of doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment received \_\_\_\_\_

X-rays taken \_\_\_\_\_

## SYMPTOMS/INJURIES

Have you been able to work since this injury?  Yes  No How many work days have you missed? \_\_\_\_\_

Prior to the injury were you able to work on an equal basis with others your age?  Yes  No

If you have had any of the following symptoms since your injury, please  check:

- Arm/shoulder pain
- Back pain
- Back stiffness
- Chest pain
- Dizziness
- Ear buzzing
- Ear ringing
- Fatigue

- Feet/toe numbness
- Hand/finger numbness
- Headaches
- Irritability
- Jaw problems
- Leg pain
- Memory loss
- Nausea

- Neck pain
- Neck stiff
- Shortness of breath
- Sleep difficulty
- Stomach upset
- Tension
- Vision blurred

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

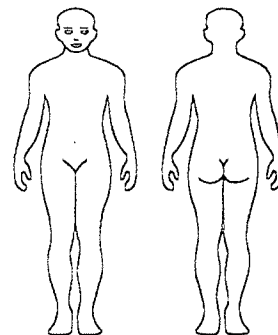
Type of pain:  Sharp  Dull  Throbbing  Numbness  
 Aching  Stinging  Burning  Tingling  
 Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Movements that are painful to perform:  Sitting  Standing  Walking  
 Bending  Lying Down



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 Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Patient Number: \_\_\_\_\_

Name: \_\_\_\_\_

Please complete the following information.

1. Does the automobile you were in have insurance coverage? YES NO
2. If YES, complete this information:  
Insurance Company's Name: \_\_\_\_\_  
Insurance Company's Phone Number: \_\_\_\_\_  
Claim Number: \_\_\_\_\_  
Medical Payment Coverage Amount: \_\_\_\_\_
3. Is there coverage for your accident under the other person's insurance company?  
YES NO (please circle)
4. If YES, complete this information:  
Insurance Company's Name: \_\_\_\_\_  
Insurance Company's Phone Number: \_\_\_\_\_  
Claim Number: \_\_\_\_\_
5. Do you have an attorney representing you? YES NO (please circle)
6. If YES, complete this information:  
Attorney's Name: \_\_\_\_\_  
Attorney's Phone Number: \_\_\_\_\_
7. Do you have health insurance coverage with your employer? YES NO
8. If YES, complete this information:  
Insurance Company's Name: \_\_\_\_\_  
Insurance Company's Phone Number: \_\_\_\_\_  
Member ID Number: \_\_\_\_\_

(send a copy of the front and back of the card if available)

9. **WE REQUIRE A COMPLETE COPY (ALL PAGES) OF THE POLICE REPORT.**

If there are any questions call Rhonda or Carol at (706) 884-8360 for help.

WHEN COMPLETED RETURN IN THE ENCLOSED ENVELOPE TO:

**ASPINWALL CHIROPRACTIC CLINIC  
302 S. GREENWOOD STREET  
LAGRANGE, GA 30240**