Clinic Name Doctor's Name: _____

Patient's Name: _____ Today's Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

Did the airbags deploy? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

Angle of Impact: **Front / Back / Left / Right / Other**: _____

If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other**: _____

1) In relation to the back of your head, was your headrest set: **Low / Middle / High**

2) Were you surprised by the impact? **Yes / No**

If "NO", how did you brace? **With Hands / With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

3b) Were you leaning forward at the time of impact? **Yes / No**

4) What type and year of vehicle were you in? _____

_____

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

5) What type and year of vehicle struck yours? _____

_____

5b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

6) Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

7) Did you feel pain immediately after the accident? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other**: _____

Doctor's Name: _____

Patient's Name: _____ Today's Date: _____

Police and Ambulance:

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom? _____

Did you go to the hospital? **Yes / No** If "YES", when? _____

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other**: _____

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**

Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**

Symptoms other than above: _____

_____ _____

Patient Signature Date

Clinic Name

Doctor's Name:_____

Patient's Name: _____ Date: _____

Address_____City_____State _____ Zip Code _____

Home Phone_____Work Phone_____ Cell Phone _____ e-mail _____

Social Security # _____Date of Birth_____Age_____ Gender: Male Female

Marital Status M S D W Occupation _____ Employer _____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

1. **Date of Collision:** _____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your injuries:** _____

_____

_____

3. **Past Health History:**

   A. **Previous illnesses you've had in your life:**

   _____

   _____

   B. **Previous injuries or traumas:**

   _____

   _____

Have you ever broken any bones? Which? _____

C. **Allergies** _____

D. **Medications:**

Medication	Reason for taking

E. **Surgeries:**

Date	Type of Surgery

Clinic Name

Doctor's Name:_____

Patient's Name: _____

Date: _____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery | Outcome

_____ | _____

_____ | _____

_____ | _____

What was the date of the beginning of your last menstrual period? _____

4. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death | Age at death

_____ | _____

_____ | _____

_____ | _____

5. Social and Occupational History: _____

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

_____

Health Insurance Info

Carrier | Ins Co phone

Address

Policy # | Group #

Patient Relationship to the insured Self Spouse Child Other

If you are covered under another persons insurance…. Please complete

Name of Insured

Address of insured

Phone of insured | Sex | Birth date

Insured's Employer

Address

Employer Phone | Plan Name

Clinic Name

Doctor's Name:_____

Patient's Name: _____

Date: _____

Auto Accident Insurance Policy Number

Carrier

Address

City State ZIP Phone

Person To Contact… Claim #

Date of Accident Patient Relationship to the insured Self Spouse Child Other

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____