CORMIER CHIROPRACTIC
HISTORY OF AUTO ACCIDENT

Patient's Name______________________________ Date of Birth____________Today's Date______________Pt. #______________

Address____Date of Accident___________________

City______________________________State_____________Zip___________Time of Accident_____________ □ am □ pm

Please describe how the accident happened:

____

____

____

□ I was the driver

□ I was the passenger sitting in the:
□ middle front seat □ right front seat □ left front seat □ middle rear seat □ right rear seat

□I was a pedestrian: □ standing □ sitting □ riding a bike □ walking □ other______________

I was traveling in a vehicle:
Year________ Make_________________ Model____

Transmission Type: □ manual □ automatic

The vehicle I was traveling in was: □ stopped □ traveling at _______m.p.h.

Road conditions were: □ dry □ damp □ wet

The road was made of: □ concrete □ asphalt □ gravel □ dirt □ Other_________________

Did your car have a head rest: □ yes □ no

If your car had a head rest, what position was it in: □ up □ middle □ down

Were you wearing a seat belt? □ yes □ no

Head position: At the time of the accident my head was looking
□ straight ahead □ to the right □ to the left □ up □ down □ other________

Brakes: Were your brakes applied at the time of the impact □ yes □ no

Elbows: My □ left or □ right elbow was on the arm rest. Other____

Hands: □ both □ right □ left hand was on the steering wheel.
□ can't remember other:____

Were you aware of the impending collision before it happened: □ yes □ no

Did you tighten your body and brace for the collision: □ yes □ no

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Your hands, as a result of the impact:
- ☐ grabbed the steering wheel tightly ☐ were forced off the steering wheel / stick shift
- ☐ other_______________

As a result of the impact, your body was thrown: ☐ forward ☐ backward ☐ right ☐ left
- ☐ turned to the right (clockwise) ☐ turned to the left (counter clockwise) ☐ can't remember

As a result of the impact your head hit the: ☐ front windshield ☐ rearview mirror
- ☐ steering wheel ☐ back of the seat ahead of me ☐ side / passenger-inside window / door
- ☐ another person's body ☐ back of my head hit the head rest ☐ side / driver inside window / door
- ☐ nothing

As a result of the impact your shoulders were: ☐ impacted with the inside of the door / car
- ☐ pressed firmly against the shoulder harness ☐ other: _______________

As a result of the collision, what other parts of your body struck the inside of the vehicle:
- ☐ ankles ☐ elbows ☐ face ☐ chest ☐ thighs ☐ forearms
- ☐ other: _______________

Did your vehicle strike or impact with a second object after the first impact: ☐ yes ☐ no
Did your vehicle strike another: ☐ car ☐ truck ☐ road / median ☐ building ☐ other_______________

Were you wearing glasses at the time of the accident: ☐ yes ☐ no
If yes, were the glasses still on following after the accident: ☐ yes ☐ no

Did you lose consciousness as a result of the accident: ☐ yes ☐ no

If yes, how long were you unconscious:_______________

Estimated cost to repair your car : $ _______________

After the accident the car was : ☐ totaled ☐ drivable ☐ not drivable

At the time of the accident, how many people were in the car with you:_______________

Names of other occupants:

1._______________ 2._______________

3._______________ 4._______________

5._______________ 6._______________

Were the occupants injured: ☐ yes ☐ no If yes, please explain_______________

Were the police called to the scene: ☐ yes ☐ no

Was a police report written: ☐ yes ☐ no

Was a ticket given to you: ☐ yes ☐ no

Was a ticket given to the other driver: ☐ yes ☐ no

Continue on next page...

As a result of the accident I felt my symptoms:

☐ immediately ☐ within one hour ☐ within 6 hours ☐ during the night

☐ next morning ☐ next day ☐ other:____

As a result of the accident I felt:

☐ headaches ☐ upper back pain ☐ chest pain / soreness ☐ wrist / elbow pain / soreness

☐ neck pain ☐ low back pain ☐ stomach pain / soreness ☐ knee / ankle pain / soreness

☐ shoulder pain ☐ numb / tingling / burning arms ☐ numb / tingling / burning legs

☐ loss of bowel / bladder control ☐ other____

____

Please list location of any cuts or bruises if applicable:____

____

Did you go to the hospital: ☐ yes ☐ no If “yes” by: ☐ ambulance ☐ private transportation

Name of hospital:______________________________ City:____

Were you admitted to the hospital: ☐ yes ☐ no If “yes”, how long was your stay___________________________

Hospital diagnosis:____

What recommendations were made: ☐ see your doctor ☐ see orthopedist / neurologist

☐ physical therapist ☐ braces / collars ☐ prescription ☐ released

☐ other____

* Please list all the Doctors you have seen since the accident:

NAME	ADDRESS	CITY	RELEASED

Are you working now: ☐ yes ☐ no

Are you currently working with restrictions: ☐ yes ☐ no

Has the doctor placed you on: ☐ total disability ☐ partial disability List restrictions:____________________

____

Please list any tests ordered by hospital or doctor:____

Since the accident do you feel: ☐ worse ☐ no improvement ☐ better ☐ other:___________________________

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