

chiropractic

Bringing Out The Best In You!

Accident/Injury Report

Patient _____ Date _____

An **accident or trauma** of any kind can cause you to have **subluxations which** can affect your physical and emotional health. **Every accident victim needs a checkup by a doctor of chiropractic.**

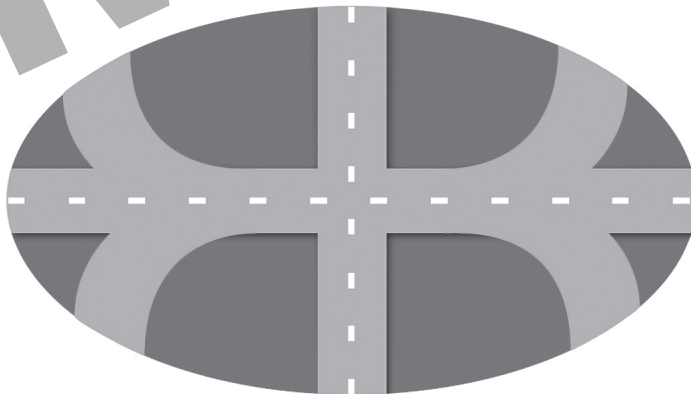
Please indicate the type of accident you were involved in:

work sports auto personal injury other _____

Date of accident _____ Time _____ Location _____

Please explain how you were injured. Be as detailed as possible. If it was an auto accident, please mention the speed of the vehicles, where your car was hit, the damage that was done, the weather conditions and your state of mind/health at the time of the accident. Let us know if you need more paper.

Please illustrate the accident with all involved vehicles (if applicable) below.



I was driving a passenger in a _____ on a _____
(type of vehicle)
_____. The other vehicle was a _____
(i.e., street or highway) (type of vehicle)

I was in front, left in front, right in back, left in back, right
 turned to the left turned to the right facing front facing back
 wearing a seat belt air bag deployed struck steering wheel struck headrest
 struck windshield other _____

Were other people in the car? no yes

If yes, were they hurt? no yes

Where were you taken after the accident and who cared for you? _____

Were X-rays, MRI or other tests done? no yes

If yes, please list _____

What treatment was given? _____

Are you receiving care from other health professionals? no yes

If yes, please give name(s), specialty and contact information _____

Injuries From The Accident

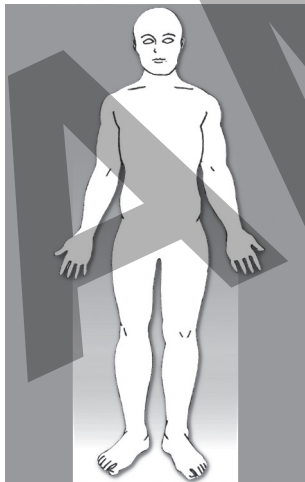
As a result of your accident, did you have any of the following (please check all that apply)

- broken bones
- dislocations
- head injuries
- surgery
- concussion

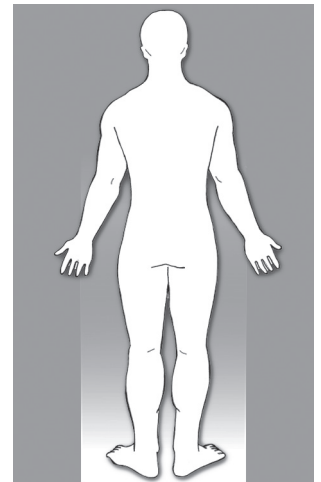
If yes to any of the above, please describe. _____

Were you knocked unconscious? no yes If yes, for how long? _____

Please use the illustrations below to show where you are experiencing symptoms.



Front _____



Back _____

As a result of this accident, do you have any of the following (please check all that apply)

- | | | |
|--------------------------------------|--------------------------------------|--|
| <input type="radio"/> dizziness | <input type="radio"/> stiff neck | <input type="radio"/> buzzing/ringing in ear |
| <input type="radio"/> memory loss | <input type="radio"/> nausea | <input type="radio"/> disturbed sleep |
| <input type="radio"/> tension | <input type="radio"/> numb feet/toes | <input type="radio"/> arm/shoulder pain |
| <input type="radio"/> upset stomach | <input type="radio"/> blurred vision | <input type="radio"/> numb hands/fingers |
| <input type="radio"/> back stiffness | <input type="radio"/> neck pain | <input type="radio"/> shortness of breath |
| <input type="radio"/> headache | <input type="radio"/> jaw problems | <input type="radio"/> forgetfulness |
| <input type="radio"/> irritability | <input type="radio"/> back pain | <input type="radio"/> fatigue |
| <input type="radio"/> chest pain | <input type="radio"/> leg pain | <input type="radio"/> other _____ |

Is there anything else you would like us to know? _____

