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

This form continues on the reverse side.

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 _____

_____

_____

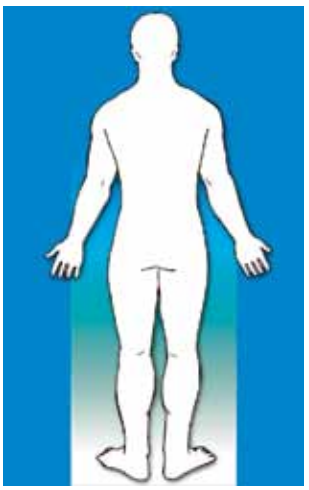
_____

❍ Back _____

_____

_____

_____



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

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

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

_____

_____