ANNAPOLIS FAMILY CHIROPRACTIC
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AUTOMOBILE ACCIDENT HISTORY FORM

Name:_____ Date of Birth:_____/_____/_____ Today's Date:_____/_____/_____

Date of Accident:_____/_____/_____ City of Accident:_____ Time of Accident:_____:_____ AM PM

Road Conditions: DRY WET ICY OTHER:_____

Weather Conditions: CLEAR CLOUDY RAINY FOGGY SNOWING OTHER:_____

Were police called to the scene? YES NO

Is there a report? YES NO

Did you go to the hospital? YES NO

If you answered yes to the above question, give the name and city of the hospital:_____

How did you get to the hospital? _____

Were X-rays taken? YES NO If yes, what areas of your body? _____

Did you sustain any bleeding cuts? YES NO If yes, where? _____

Did you sustain any bruises? YES NO If yes, where? _____

What did the hospital do for your injuries? _____

How long were you at the hospital? _____

ABOUT THE ACCIDENT:

Where were you seated in the vehicle? _____

Were you aware of the impending collision or did it take you by surprise? _____

Did you lose consciousness? YES NO If yes, for how long? _____

Did you experience a flash of light or explosion in your head? YES NO

Did you have or become (please circle)… CONFUSED DISORIENTED LIGHTHEADED DIZZY
NAUSEATED BLURRED VISION RING/BUZZ IN EARS

If you still have any of these symptoms, which ones do you still have? _____

Are you currently suffering from any of the following (please circle)? RESTLESSNESS IRRITABILITY
DIFFICULTY CONCENTRATING SLEEPLESSNESS FORGETFULNESS
REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL

What position was your headrest in? LOW MEDIUM HIGH NOT INSTALLED

Were you wearing a seatbelt? YES NO If yes, was it a LAPBELT or a SHOULDER/LAPBELT ?

Was your head pointed straight forward at the time of the collision? YES NO

If you answered no to the above question, which way was your head pointing and by how much?

_____

Was the trunk of your body pointing straight forward? YES NO

If you answered no to the above question, which way was the trunk of your body pointed and by how much?

_____

(OVER)

List the year, make, and model of the vehicle you were in:_____

Please list the action of your vehicle at the time of impact (please circle):

STOPPED FOR TRAFFIC

STOPPED FOR PEDESTRIAN

STOPPED AT INTERSECTION

TRAVELING SLOWER THAN THE POSTED SPEED LIMIT

TRAVELING FASTER THAN THE POSTED SPEED LIMIT

TURNING LEFT

TURNING RIGHT

CROSSING AN INTERSECTION

What is the estimated cost damage to your vehicle? _____

What is the year, make, and model of the other vehicle? _____

Was the other vehicle moving at the time of the collision? YES NO If yes, how fast? _____

Was it slowing down, speeding up, or traveling at a steady speed? _____

Pease give the estimated cost damage to the other vehicle (please circle): MINIMAL MODERATE EXTENSIVE

Please describe to the best of your knowledge, what happened during this accident (make a diagram if necessary):

_____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE