

Automobile Accident Case History

Name _____ Today's Date ____/____/____

Date of Injury _____ Attorney _____

Martial Status?

Married Separated Divorced Widowed Single #Children ____

Smoking? (Packs/Day ____ Years ____)

Non-Smoker Smoker

Drinking?

Non-Drinker Drinker

Employer _____ Job Title _____

Location of Accident?

Name of Roadway _____

Nearest Intersection _____

City _____ State _____ Zip _____

Road Conditions?

Dry Damp Wet Icy Other _____

Time of Day?

Dawn Day Dusk Night

Your Vehicle?

Year _____ Make _____

Model _____

Direction of Travel?

North South East West

Position of Your Vehicle?

Stopped Turning Left Turning Right Slowing Down

Backing up Traveling Straight Other _____

Other Vehicle(s) (if applicable)

Year _____ Make _____

Model _____

Direction of Travel?

North South East West

Position of Your Vehicle?

Stopped Turning Left Turning Right Slowing Down

Backing up Traveling Straight Other _____

Were you the?

Driver Passenger

(If Passenger Front Seat Back Seat)

Number of Hands on Steering Wheel?

One Both

Were the Brakes Applied?

Yes No

Did you feel your body go?

Forward then Back Back then Forward Right Left

Did you body strike anything in the car?

Yes No What? _____

Were you knocked unconscious?

Yes No How long? _____

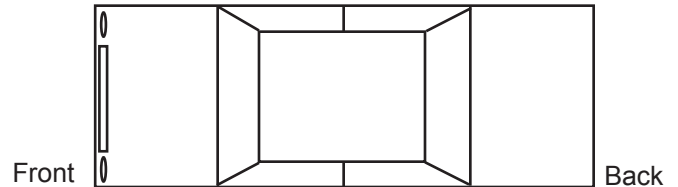
Which direction were you looking?

Forward then Back Back then Forward Right Left

Were you wearing a seat belt?

Yes No

Area of Damage



Description of Accident _____

Diagram of Accident

Shoulder Harness?

Yes No

Air bag?

Yes No

Were you aware of the impending collision?

Yes No

Other People in the car?

Yes No

Number of Passengers ____

Were the police called to the scene?

Yes No

Report taken?

Yes No

Damage to car?

Minor Moderate Severe Totaled Drivable

Est. Damage Cost? _____

Initial Symptoms

None Headache Dizziness Disorientation Shock Neck Pain/Stiffness Thoracic Pain/Stiffness Lumbar/Stiffness
Numbness Other_____

Present job involves

Office work only Some light lifting Repetitive Lifting _____lbs Maximum lifting _____lbs Repetitive squatting
Repetitive bending Repetitive stooping Repetitive kneeling Factory work

Hours per day?_____

Days per week?_____

How long with employer?_____

Job description changes as a result of injury?

Yes No

If Yes, how?_____

Have you had same or similar complaints in the past?

Yes No

If so, what were they_____

AACH

THIS SECTION TO BE COMPLETED BY THE DOCTOR OF CHIROPRACTIC

Treatment History (TX HX)

1. Dr. _____ Specialty _____ Date ___/___/___ Diagnosis _____

TX Type _____ TX Frequency _____

Current TX

Yes No

Work restrictions

Yes No

Number of times seen _____ **Referred to** _____

Notes _____

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