Glaza Chiropractic Center

Automobile Accident

Name: _____ **Chart #:** _____ **Today's Date:** _____ **Accident Date:** _____

DESCRIBE THE VEHICLE

Patient's Vehicle Type:
- ☐ Bus ☐ Van ☐ Sport-utility
- ☐ Sports car ☐ Truck
- ☐ Coupe ☐ Station Wagon
- ☐ Sedan ☐ Pick-up truck

Vehicle Size:
- ☐ Compact ☐ Mini
- ☐ Full-Size ☐ Sub-compact
- ☐ Light ☐ Semi
- ☐ Mid-Size

Position in vehicle:
- ☐ Driver ☐ Rear left passenger
- ☐ Front mid passenger ☐ Rear mid passenger
- ☐ Front right passenger ☐ Rear right passenger

DESCRIBE THE ACCIDENT

Date of Accident:

Action of patient vehicle:
- ☐ Crossing intersection
- ☐ Stopped at intersection
- ☐ Stopped for pedestrian
- ☐ Stopped in traffic
- ☐ Turning right
- ☐ Turning left
- ☐ Traveling speed limit
- ☐ Faster than speed limit
- ☐ Slower than speed limit

Patient's Vehicle was hit:
- ☐ Head-on
- ☐ On the left front
- ☐ On the right front
- ☐ On the left rear
- ☐ On the right rear
- ☐ Was rear-ended
- ☐ Sideswiped on left
- ☐ Sideswiped on right

Damage:
- ☐ Complete
- ☐ Extensive
- ☐ Minimal
- ☐ Moderate

Damage to other vehicle:
- ☐ Complete
- ☐ Extensive
- ☐ Minimal
- ☐ Moderate

Describe other vehicle:
- ☐ A compact car ☐ A mini-van
- ☐ A full-sized car ☐ None of the above
- ☐ A mid-sized car
- ☐ A subcompact car
- ☐ A semi-trailer
- ☐ A light truck
- ☐ A pick-up truck
- ☐ A sport-utility veh.
- ☐ A full-sized van

Weather Conditions:
- ☐ Clear ☐ Rainy
- ☐ Cloudy ☐ Snowing
- ☐ Drizzling ☐ Storming
- ☐ Foggy ☐ Sunny

Road Conditions:
- ☐ Damp ☐ Snowed over
- ☐ Dry ☐ Wet
- ☐ Dry with icy patches ☐
- ☐ Iced over ☐

Time of Day:
- ☐ The dawn
- ☐ The day
- ☐ Dusk
- ☐ The night

Visibility:
- ☐ Fair
- ☐ Good
- ☐ Poor
- ☐

DESCRIBE MOMENT OF IMPACT

Body Position at impact:
- ☐ Leaning forward
- ☐ Slouched in seat
- ☐ Straight
- ☐ Turned left
- ☐ Turned right

Direction body was thrown:
- ☐ Backward then forward
- ☐ Forward then backward
- ☐ To the left
- ☐ To the right
- ☐ About the vehicle
- ☐ Outside the vehicle
- ☐ Under the vehicle

Head position at impact:
- ☐ Straight ☐ Turned left
- ☐ Tilted forward ☐ Turned right

Direction head was thrown:
- ☐ Backward then forward ☐ Side to side
- ☐ Forward then backward ☐

Type of passive restraint:
- ☐ A lap belt
- ☐ A shoulder belt
- ☐ A shoulder-lap belt
- ☐

Did the airbags deploy?
- ☐ Yes ☐ No

Did you brace for impact?
- ☐ Yes
- ☐ No

Position of head rests:
- ☐ in the high position
- ☐ in the low position
- ☐ in the middle position
- ☐ not installed

Additional Notes/Comments:

Did your vehicle go into a spin/roll? _____ Were brakes being applied? _____

Your approximate speed during impact? _____ Other vehicle? _____

Did you hit anything inside the vehicle during impact? (mark chart below)

	Dashboard	Windshield	Door	Seat	Steering	Ceiling	Window
Head							
Lt Shoulder							
Rt Shoulder							
Lt Arm							
Rt Arm							
Lt Elbow							
Rt Elbow							
Lt Wrist							
Rt Wrist							
Lt Hip							
Rt Hip							
Lt Knee							
Rt Knee							
Lt Ankle							
Rt Ankle							

Did you have any bruises/contusions? _____ Where? _____

Post Injury

Name: _____ **Chart #:** _____ **Today's Date:** _____ **Accident Date:** _____

WHAT HAPPENED IMMEDIATELY FOLLOWING THE ACCIDENT?

What was your initial reaction?

- ☐ Shaken
- ☐ Light headed
- ☐ Upset
- ☐ Weak
- ☐ Nervous
- ☐ Confused
- ☐ Frightened
- ☐ Dazed
- ☐ Distressed
- ☐ Dizzy

Where did you have pain?

- ☐ Head
- ☐ Neck
- ☐ Right shoulder
- ☐ Left shoulder
- ☐ Right arm
- ☐ Left arm
- ☐ Right elbow
- ☐ Left elbow
- ☐ Right forearm
- ☐ Left forearm
- ☐ Right wrist
- ☐ Left wrist
- ☐ Right hand
- ☐ Left hand
- ☐ Chest
- ☐ Rib cage
- ☐ Upper back
- ☐ Mid back
- ☐ Abdomen
- ☐ Lower back
- ☐ Pelvis
- ☐ Right buttock
- ☐ Left buttock
- ☐ Right leg
- ☐ Left leg
- ☐ Right hip
- ☐ Left hip
- ☐ Right thigh
- ☐ Left thigh
- ☐ Right knee
- ☐ Left knee
- ☐ Right shin
- ☐ Left shin
- ☐ Right ankle
- ☐ Left ankle
- ☐ Right foot
- ☐ Left foot

Did you receive any cuts?

- ☐ Head
- ☐ Neck
- ☐ Right shoulder
- ☐ Left shoulder
- ☐ Right arm
- ☐ Left arm
- ☐ Right elbow
- ☐ Left elbow
- ☐ Right forearm
- ☐ Left forearm
- ☐ Right wrist
- ☐ Left wrist
- ☐ Right hand
- ☐ Left hand
- ☐ Chest
- ☐ Rib cage
- ☐ Upper back
- ☐ Mid back
- ☐ Abdomen
- ☐ Lower back
- ☐ Pelvis
- ☐ Right buttock
- ☐ Left buttock
- ☐ Right leg
- ☐ Left leg
- ☐ Right hip
- ☐ Left hip
- ☐ Right thigh
- ☐ Left thigh
- ☐ Right knee
- ☐ Left knee
- ☐ Right shin
- ☐ Left shin
- ☐ Right ankle
- ☐ Left ankle
- ☐ Right foot
- ☐ Left foot

Type of emergency care provided?

- ☐ Bandaging
- ☐ Bracing
- ☐ CPR
- ☐ A neck collar
- ☐ Splinting
- ☐
- ☐
- ☐

Immediate destination after accident?

- ☐ To work
- ☐ Home
- ☐ To School
- ☐ To a hospital
- ☐ To a clinic
- ☐ To a doctor's office

Who drove you?

- ☐ Himself
- ☐ Herself
- ☐ A friend
- ☐ Ambulance
- ☐ A family member
- ☐ Police
- ☐ Taxicab
- ☐ Father
- ☐ Mother
- ☐
- ☐
- ☐

Did you lose consciousness?

☐ Yes ☐ No ☐ Unsure

If yes, for how long?

- ☐ A few seconds
- ☐ A few minutes
- ☐ About 5 minutes
- ☐ About 15 minutes
- ☐ About 30 minutes
- ☐ Less than an hour
- ☐ More than an hour
- ☐ A couple of hours

POST INJURY TREATMENT:

Were you admitted to a hospital?

- ☐ Yes
- ☐ No

Name of hospital/clinic:

- ☐ _____
- ☐ Local hospital Emergency Room

Examining Physician:

Date of initial visit/or:

- ☐ _____
- ☐ A few days ago
- ☐ Last week
- ☐ A couple of weeks ago
- ☐ Several weeks ago
- ☐ About a month ago
- ☐ Several months ago
- ☐ More than a year ago
- ☐ Several years ago
- ☐ During childhood

Date of discharge/or:

- ☐ _____
- ☐ A few days ago
- ☐ Last week
- ☐ A couple of weeks ago
- ☐ Several weeks ago
- ☐ About a month ago
- ☐ Several months ago
- ☐ More than a year ago
- ☐ Several years ago
- ☐ During childhood

Diagnosis of injury:

Circle what diagnostic tests were performed at the hospital?

1. **X-ray** **What part of the body?** _____
2. **CT Scan** **What part of the body?** _____
3. **MRI** **What part of the body?** _____

What medications were prescribed? _____

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