

Back In Line Chiropractic Center, Inc.

Automobile Accident Form

Patient Name: _____ Date: ____/____/____

Social Security #: _____ Date of Birth: ____/____/____

Date of Injury: ____/____/____ Time of Injury: _____ AM PM

Location of Accident: _____

Were you the driver passenger pedestrian?

What is the estimated damage to your vehicle? \$ _____

Yes No Do you have automobile personal injury insurance coverage?

Name/Address/Phone #: _____

What is your automobile insurance medical coverage limit? \$ _____

What is your claim #: _____

Yes No Have you reported this injury to your car insurance company?

Yes No Do you know the claim adjuster's name? _____

Yes No Did the police come to the scene of the accident and make a report?

Yes No Was anyone issued a citation? Who? Driver of your car Driver of other car

Yes No Do you have an attorney for this case? Name / Address / Phone: _____

Where was your car hit? Front Back Driver's Side Passenger's Side

Yes No Was your car moving? MPH ____ Yes No Was the other car moving?

Please describe the accident: _____

How did you feel after the accident? _____

Yes No Did you lose consciousness? Yes No Did you go to the hospital?

Check symptoms you have noticed since the accident:

Headache	Irritability	Numbness in Toes	Cold Feet
Neck Pain	Chest Pain	Shortness of breath	Ringling in Ears
Neck Stiffness	Dizziness	Fatigue	Loss of Balance
Sleeping Problems	Head seems heavy	Depression	Fainting Spells
Mid Back Pain	Lower Back Pain	Pins & Needles in arms	Tension
Numbness in Hand	Nervousness	Pins & Needles in legs	Loss of Smell
Loss of Taste	Loss of Memory	Cold Hands	Sciatic Pain
Bleeding (location) _____		Stitches (location) _____	
Lower Back Stiffness	Lower Extremity Pain (location) _____		
Upper Extremity Pain (location) _____		Missed days from work (#) _____	

At the time of impact your vehicle was:

Slowing down Stopped Gaining speed Moving at steady speed

At the time of impact the other vehicle was:

Slowing down Stopped Gaining speed Moving at steady speed

During and after the crash, your vehicle:

Kept going straight, not hitting anything Spun around, not hitting anything
Kept going straight, hitting car in front Spun around, hitting another car
Was hit by another vehicle Spun around, hitting object other than car

Describe yourself during the crash.

Check only the areas that apply to you

- You were unaware of the impending collision.
- You were aware of the impending crash and relaxed before the collision.
- You were aware of the impending crash and braced yourself.
- Your body, torso, and head were facing straight ahead.
- You had your head and/or torso turned at the time of collision:
 Turned to left Turned to right
- You were intoxicated (alcohol) at the time of crash.
- You were wearing a seat belt.
 If yes, does your seat belt have a shoulder harness? Yes No
- You were holding onto the steering wheel at the time of impact.

Indicate if your body hit something or was hit by any of the following:

Please draw lines and match the left column to the right column. (Please print form to fill in this section)

Head	Windshield
Face	Steering Wheel
Shoulder	Side Door
Neck	Dashboard
Chest	Car Frame
Hip	Another Occupant
Knee	Seat
Foot	Seat belt

Check if any of the following vehicle parts broke, bent, or were damaged in your car:

Windshield	Seat frame	Knee bolster
Steering wheel	Side/rear window	Other _____
Dashboard	Mirror	Other _____

Rear-end collisions only

Answer this section only if you were hit from the rear.

Does your vehicle have:

- Moveable head restraints
- Fixed, non-moveable head restraints
- No head restraints

Please indicate how your head restraint was positioned at the time of the crash.*

- At the top of the back of your head
- Midway height of the back of your head
- Lower height of the back of your head
- At the back of your neck
- At the level of your shoulder blades (upper back) below your neck

All types of collisions

Answer this section regardless of the type of crash, indicating those relevant to your case.

Yes No

- Did any of the front of your side structures, such as side door, dashboard, or floor board of your car, dent inward during the crash?
- Did the side door touch your body during the crash?
- Were your hands on the steering wheel or dashboard during the crash?
- Did your body slide under the seat belt?
- Was a door of your vehicle damaged to the point where you could not open the door?

Emergency Department

Yes No

- Did you go to the emergency department after the accident?
What is the name of the emergency department? _____
When did you go (date and time)? _____
- Did you go to the emergency department in an ambulance?
- Did you or another person drive you to the emergency department?
- Were you hospitalized overnight?
- Did the emergency department doctor take X-rays? Check what was taken:
Skull
Neck
Low Back
Arm or Leg
- Did the emergency department doctor give you pain medication?
- Did the emergency department doctor give you muscle relaxants?
- Did you have any cuts or lacerations?
- Did you require any stitching for cuts?
- Were you given a neck collar or back brace to wear?

When did you first notice any pain after injury?

Immediately _____ Hours After Injury _____ Days After Injury

If you did not see a doctor for the first time within the first week after injury, indicate why.

Check all that apply:

- No pain was noticed
- No transportation
- No appointment schedule available
- Work/home schedule conflicts

If you did not see a doctor for the first time within the first month after injury, indicate why.

Check all that apply:

- No pain was noticed
- No transportation
- I thought pain would go away
- I self-treated with over-the-counter drugs
- No appointment schedule available
- Work/home schedule conflicts
- I had no insurance or money
- I took hot showers, used ice, heat

Have you been unable to work since injury?

Yes No If yes, were you off work partially or completely?

Please list date(s) off work: _____ / _____ / _____ to _____ / _____ / _____