Corbett Chiropractic
& Health Enhancement

Automobile Accident History

Name _____ Date _____

Date of accident_____ Time of accident _____AM/PM

City of accident_____ Street of accident _____

Road condition at time of accident ____Wet ____Dry ____Icy Other_____

Did the police come to accident scene? ____ Yes ____No Is there a report? ____Yes ____No

Did you go to a hospital? ____Yes ____ No
If yes, name and city of hospital _____
How did you get to hospital? _____
What parts of your body were x-rayed at hospital? _____
How did hospital treat your injuries? _____
How long was hospital stay? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact or did impact catch you by surprise?
_____ Aware _____Surprise

Did you lost consciousness (black out) upon impact? ____Yes ____No If yes, how long? _____

Did you experience a flash or light or explosion in your head? ____Yes ____No

Did you experience any of the following from the accident? (Please check all that apply)
____Confused ____ Disoriented ____Light headed ____ Dizzy
____Nausea ____Blurred Vision ____Ring/buzz in ears

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

Are you currently suffering from any of the following? (Please check all that apply)
____Restlessness ____Irritable
____Difficulty concentrating ____Difficulty with memory
____Sleeplessness ____Forgetfulness
____Reduced tolerance to heat ____Reduced tolerance to alcohol

Approximately how far is the top of the vehicle headrest or seatback from the top of your head?
_____ Inches ___Above or ___Below

Were you wearing a seat beat? ____Yes ____No If yes, ____Lab Belt ____Shoulder belt

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List year, make, model of vehicle you were in

Year_____ Make_____ Model _____

Was your car stopped at time of impact? ____Yes ____No

Slowing down ____Yes ____No

Gaining speed ____Yes ____No

Traveling at steady rate of speed ____Yes ____No

On what part of the automobile did your following body parts hit?

Head hit_____ Chest hit _____

Right/left shoulder hit_____ Right/left are hit_____

Right/left hip hit_____ Right/left leg hit_____

Right/left knee hit_____ Other_____

Did you receive any injury or bruise from seat belt? ____Yes ____No

If yes, please describe._____

What is the estimated cost of damage to the vehicle you were riding in? $_____

Which of the following car parts were damaged during the accident? (Please check all that apply)

____Windshield ____Right window ____Left window

____Front seat back ____Steering wheel ____Other_____

Was the trunk of your body pointed straight forward at the time of the collision?

____Yes ____No If no, how was it turned?_____

Was your head pointed straight forward at the time of the collision?

____Yes ____No If no, how was it turned and by how much?_____

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

Year_____ Make_____ Model_____

Was the other vehicle moving at the time of collision? ____Yes ____No.

If yes, what was its approximate speed? _____MPH

If other vehicle was moving at the time of collision, was it _____? (Check one)

____Slowing down ____Gaining speed ____Traveling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident?

_____

_____

_____

_____