Choice Chiropractic & wellness
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PLEASE ANSWER ALL QUESTIONS COMPLETELY

Dear Patient: We need this information because we care enough to know and your answers will help us determine if chiropractic can help you. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? (if known) _____
5. What street or intersection were you on when the accident occurred? _____
6. What direction were you traveling in? _____
7. What city did the accident occur in? _____
8. What state did the accident occur in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? - yes -no
    If yes, please describe_____
11. Where were you sitting in the vehicle during the accident?_____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)
    - kept going straight
    - kept going straight hitting a car in front
    - was hit by another vehicle
    - spun around
    - spun around and hit a stationary object
    - hit a stationary object
18. Did you lose consciousness during the accident? -yes - no
19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -no - yes
If yes, please describe_____

23. Did your face hit anything during the accident? -no - yes
If yes, please describe_____

24. Did your shoulders hit anything during the accident? -no - yes
If yes, please describe_____

25. Did your neck hit anything during the accident? -no - yes
If yes, please describe_____

26. Did your chest hit anything during the accident? -no - yes
If yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes
If yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes
If yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes
If yes, please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest
- non-movable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totaled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
- floorboards - side door - dashboard - (other)_____

36. Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37. Did you go to the hospital? - yes -no
If no, why? _____
(If no, skip questions 38-43)

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized overnight? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxers - neck brace - other _____

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were x- rays taken at the hospital? - yes -no
If yes, which area was taken? _____