SALAMA CHIROPRACTIC CENTER

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Automobile Accident Information

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? (in dollars) ______
5. What city did the accident occur in? ______
6. What state did the accident occur in? ______
7. What type of impact was the auto accident?
   ❑ rear ended ❑ hit on drivers side ❑ hit another vehicle form behind ❑ hit on passenger side
8. Did your vehicle hit anything after the accident? if yes, please describe ______
9. Where were you sitting in the vehicle during the accident?
   ❑ driver ❑ rear left passenger ❑ front passenger ❑ rear right passenger
10. Did you know the accident was coming?
   ❑ unaware of impending collision ❑ aware of impending collision ❑ aware of impending collision and I braked
11. What type of vehicle were you in?
   ❑ compact car ❑ mid size car ❑ full size car ❑ truck
   ❑ SUV ❑ minivan ❑ van ❑ other
12. What type of vehicle impacted yours?
   ❑ compact car ❑ mid size car ❑ full size car ❑ truck
   ❑ SUV ❑ minivan ❑ van ❑ other
13. At the time of the impact, how fast was your vehicle moving?
   ❑ slowing down ❑ stopped ❑ gaining speed ❑ moving steady speed
14. Did you lose consciousness during the accident? ❑ yes ❑ no
15. Did you have your seatbelt on during the accident? ❑ yes ❑ no
16. Did you go to the hospital? ❑ yes ❑ no If no, why and skip 38-43 ______
17. How did get to the hospital?
   ❑ ambulance ❑ police car ❑ walked ❑ helicopter ❑ drove self ❑ other
18. What was the name of the hospital? ______
19. Were you hospitalized over night? ❑ yes ❑ no
20. Check what you were prescribed at the hospital
   ❑ pain medication ❑ muscle relaxors ❑ neck brace
21. Did you receive any stitches for any cuts at the hospital? ❑ yes ❑ no
22. Were x rays taken at the hospital? If yes, which area was taken?
   ❑ neck ❑ skull ❑ mid back ❑ lower back ❑ pelvis ❑ hips
   ❑ leg ❑ knee ❑ foot ❑ shoulder ❑ arm ❑ other

Patient Name (print) ______ Date ______

Patient Signature ______