DEER VALLEY CHIROPRACTIC
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AUT0 ACCIDENT CONSULTATION / HISTORY

Date of Accident: ________________ Date of Exam: _____________ Doctor: _____________________

PLEASE FILL IN OR CIRCLE ALL QUESTIONS ASKED

Patient's Name: ____
Have you missed work due to the accident? YES NO If Yes, Dates missed: _________________________
Was the accident on-the-job? YES NO
Were you the: Driver Front Seat Passenger Rear Seat Passenger Lt Middle Rt
Motorcycle Operator Motorcycle Passenger Other: ____
Vehicle was driven by: ____
Did your car strike another? YES NO Did the other car strike You? YES NO
Were you struck from: BEHIND DRIVER'S SIDE PASSENGER'S SIDE FRONT Other ___________
Were police on the scene? YES NO If Yes, was a report made? YES NO
Were traffic citations issued to: You--- Driver of your car----Driver of the other car---None---Unknown
Accident Description & Chief Complaint:
____
____
____
Was your car heading: North South East West on _________________________ (Street/Highway)
Was the other car heading: North South East West on _________________________ (Street/Highway)
Your Vehicle (Year, Make, Model) ____
Your estimated speed at the moment of impact: Full Stop Slowing Accelerating Constant Speed
Other Vehicle (Year, Make, Model) ____
Time of Day: Daylight Dawn Dusk Dark
Road Conditions: Dry Damp Wet Snow Ice Other ____________________________________
Head Rests Restraints: YES NO Adjustable: UP Down Don't Know
If adjustable, was the position altered by the accident? YES NO
Was the seat back adjustment altered by the accident? YES NO
Were seat belt restraints used? YES NO Type: LAP LAP and SHOULDER CAR SEAT
Did air bag deploy? YES NO If Yes, were you struck? YES NO Were you Burned? YES NO
Body position: Good Forward lean Other ____
Head position: Forward Left ______ Right ______ Up ______ Down ______
Hands: One on wheel Two on wheel N/A
Brakes applied at impact? YES NO
Aware of impending crash? YES NO
Did you lose consciousness? YES NO If YES, for how long? _______________

During the Crash:
Did you strike any body parts in the vehicle? YES NO If Yes, describe _________________________
Did vehicle strike any objects after the crash? YES NO If Yes, describe _________________________
Were you wearing a hat or glasses? YES NO If Yes, were they still on after the crash? YES NO
Where did you go after the accident? Home Work Hospital Mode of transportation ______________
Emergency room: YES NO Hospital name: ____
X-rays Taken: YES NO Body parts X-rayed ____
Cervical collar given: YES NO Ice given: YES NO
Rx or Medication given: YES NO Type: ____
Other Doctors / Clinics / Therapists: (Seen since the Accident Excluding Above Information)

Doctor: _________________________________ Specialty: ________________ Date first seen: ___________