Active Chiropractic

1 S. Main Street, Chagrin Falls, OH 44022

(440)893-8800 (p) ~ (440)893-9422 (f)

AUTOMOBILE ACCIDENT HISTORY

Date _____

Name _____ Birthdate _____

ACCIDENT HISTORY

Date of Accident: _____ Time of Accident: _____ A.M. P.M.

State how the Accident happened in your own words:

_____

_____

What type of vehicle were you in? Make: _____Year: _____

What type of other vehicle was involved in the accident?

Car Truck Motorcycle SUV Other: _____ **Size and Type**: _____

Did your vehicle strike anything? **Yes No** If yes: **Another Car Sign Tree Other:**_____

Were you driving? **Yes No** Was it your car? **Yes No** If not, whose? _____

Were you a passenger? **Front Back Right Side Left Side** Were you rotated in seat? **Yes No** Seat belts on? **Yes No**

Other people in car? **Yes No** Names:_____

Were they injured? **Yes No** Please explain: _____ _____

_____

Was it? **Daylight Night Dark Dawn** What were the weather/traffic conditions? _____

How fast were you going? _____ Road type**? 2 Lane 4 Lane Gravel Tar**

Was there damage to your car and to what extent? _____

_____

Your automobile insurance company:

Name _____ Claim #_____ Is this covered under Medpay? Y N

Adjuster Name _____ Phone number _____

Other party insurance company: (If another party is responsible for the accident)

Name _____ Claim #_____

Adjuster Name _____ Phone number _____

Have you retained an attorney? **Yes No** Name and Phone:_____

INJURIES AND SYMPTOMS

Did you hit part of your body during the collision, for example: head on dash, chest on steering wheel? **Yes** **No**

If yes, which part and how? _____

Where did you feel pain immediately after the accident? _____

Since this injury are your symptoms: **Improving** **Getting Worse** **Same**

Any new symptoms? **Yes** **No** If Yes, explain_____

Have you ever had any complaints in the involved area before? **Yes** **No** If Yes, explain _____

Are your work activities restricted as a result of this accident? **Yes** **No** If Yes, explain _____

Were you completely conscious after the impact? **Yes** **No** Do you remember the impact? **Yes** **No**

Were you taken to the hospital after the accident? **Yes** **No** Where?_____

What treatment was given? _____

Were you hospitalized? **Yes** **No** If yes, for how long? _____

Was any other doctor consulted after your accident? **Yes** **No**

If so, what was the doctor's name and specialty?_____

What treatment was given? _____

Are you still under care with this doctor? **Yes** **No**

Have you had any time loss from work? **Yes** **No** If yes, from _____to _____

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature: _____ Date: _____