Koch Chiropractic Center
Automobile Accident History

Patient Name _____ **Today's Date** _____ **Date Of Accident**_____

The speed of your vehicle was: ☐Stopped ☐Accelerating ☐Constant ☐Slowing _____ mph

What Was The Other Vehicle's Speed At Impact? ☐ Stopped ☐ _____ mph

Head Restraints: ☐None ☐Built into seats ☐In the up position ☐In the down position ☐Don't know

Where Was Your Car Struck? ☐ Front ☐ Rear ☐ R-Side ☐ L-Side ☐ R-Front Corner
☐ L-Front Corner ☐ R-Back Corner ☐ L-Back Corner ☐ Roll -over ☐ Other_____

Your Position In The Car Was? ☐Driver ☐Front right passenger ☐Back left passenger ☐Back right passenger

Your Vehicle Was A? ☐ Subcompact ☐ Compact ☐ Mid-Size Car ☐ Full Size Car
☐ Small SUV ☐ Mid-Size SUV ☐ Large SUV ☐ Minivan ☐ Full Size Van
☐ Wagon ☐ Small Truck ☐ Full Size Truck ☐ Delivery Truck ☐ Tractor Trailor
☐ Other _____

Other Vehicle Was A? ☐ Subcompact ☐ Compact ☐ Mid-Size Car ☐ Full Size Car
☐ Small SUV ☐ Mid-Size SUV ☐ Large SUV ☐ Minivan ☐ Full Size Van
☐ Wagon ☐ Small Truck ☐ Full Size Truck ☐ Delivery Truck ☐ Tractor Trailor
☐ Other _____

Time of Day: ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road Conditions: ☐Dry ☐Damp ☐Wet ☐Snow-Covered ☐Icey

Were You Wearing Your Seatbelt At The Time Of Impact? ☐ Yes ☐ No ☐ Unknown

Were The Brakes Applied At The Time Of Impact? ☐ Yes ☐ No ☐ Unknown

Did The Airbags Deploy At The Time Of Impact? ☐ Yes ☐ No ☐ Unknown

Did The Seat Break At The Time Of Impact? ☐ Yes ☐ No ☐ Unknown

Were Your Hands On The Steering Wheel? ☐Both Hands ☐Left Hand ☐Right Hand ☐Can't recall

Head Apparel: ☐Knocked Off ☐Hat ☐Glasses ☐Both ☐Neither

Location Of Accident _____

Body Position at Impact: ☐Upright ☐Leaning Forward ☐Turned Left ☐Turned Right ☐Can't Recall

Head Position At Impact: ☐Not Turned ☐Turned Left ☐Turned Right ☐Can't Recall

Fill out other side Please ⇨

We You Aware That Accident Was Going To Occur?: ☐ Yes ☐ No

Did Your Body Hit Anything Inside The Vehicle? ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Window ☐ Other _____

What Part Of Your Body Hit The Above Part In Your Car? ☐ Head ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Other _____

Where Did You Go After The Accident? ☐ Hospital ☐ Chiropractor ☐ Family Doctor ☐ Home ☐ Work ☐ Other

Did You Lose Consciousness? ☐ Yes ☐ No

Police At Crash Site: ☐No Police On-Scene ☐Police On Scene And Report Was Made ☐Police On Scene But No Report Was Made ☐Can't Remember

Immediate Symptoms: ☐Back Pain Disorientation ☐Dizziness ☐Headache ☐Left/Right Arm Numbness ☐Left/Right Arm Pain ☐Nausea ☐Neck Pain ☐Left/Right Leg Numbness ☐Left/Right Leg Pain

Estimated Property Damage To Your Vehicle:_____

Estimated Property Damage To Other Vehicle:_____

In Detail, Describe How The Accident Occurred: _____

_____

_____

_____

_____

Were You Admitted To The Hospital? ☐No ☐Yes Date Admitted:_____**Duration Of Stay? _____**

If You Went To The Hospital, When? ☐At The Time Of The Accident ☐Next Day

How Did You Get To The Hospital? ☐Ambulance ☐Police Car ☐Private Transportation

Name Of Hospital, or Physician: _____

What Treatment Was Given? ☐ None ☐ Placed In A Cervical Collar ☐ X-Rayed
☐ Given Pain Medication ☐ Given Instructions Regarding Concussions / Sprains-Strains
☐ Stitches / Bandaged ☐ Physical Therapy ☐ Referred To This Office For Treatment
☐ Instructed To Call An Orthopedic Surgeon / Private Physician
☐ Other _____

Immediately After The Accident Were You In Pain? ☐ Yes ☐ No

Last Page Please ⇨

If You Were In Pain, What Part Of The Body Hurt? ☐ Headache ☐ Head ☐ Neck
☐ TMJ(jaw) ☐ Shoulder ☐ Upper Back ☐ Mid Back ☐ Ribs ☐ Arm
☐ Low Back ☐ Hip ☐ Leg ☐ Foot ☐ Ankle ☐ Other_____

Please Describe The Pain: ☐Achey ☐Burning ☐Dull ☐Numb ☐Sharp ☐Shooting
☐Sore ☐Stiff ☐Tingling

Have You Experienced These Symptoms BeforeThis Accident? ☐ Yes ☐ No ☐ Similar
If Yes, When?_____

After The Accident How Did You Feel? ☐ Dizzy / Dazed ☐ Disoriented ☐ Unconscious
☐ Nervous ☐ Nauseous ☐ Upset ☐ Weak ☐ Other

If You Were Not Immediately In Pain, When Did Symptoms First Begin?

_____

Have You Seen Any Other Doctor Or Had Any Diagnostic Tests As A Result Of This Accident? ☐ Yes
☐ No Tests: ☐ MRI ☐ EMG ☐ X-rays **Doctor's Name:**_____

Have You Lost Any Time From Work Due To This Accident? ☐Yes ☐ No From _____To_____

Patient Signature: _____ **Date:** _____