Bidwell CHIROPRACTIC

Patient's Name: _________________________
Date: ___________________

What was the date of the accident?______________ What time did the accident occur?______________

Do you have an attorney? □ No □ Yes If yes, please provide the following information:

Name ______________________________ Phone number ______________________________

Address ______________________________________________________________________________

How many vehicles were involved?____________________

Did you miss any work? If yes, how long ____________________

Where you the driver of the car? □ No □ Yes If not, where were you sitting? __________________________

Who else was in the car? ______________________________________________________________________

What was the estimated damage to the vehicle you were in? ___________________

What city and state did the accident occur in? _____________________________

What street or intersection were you on when the accident occurred? ________________________

What type of impact was the accident? _____________________________________

Did you know the accident was coming? □ No □ Yes

What type of vehicle were you in? _______________________

What type of vehicle hit yours? _______________________

At the time of the impact, how fast was your vehicle moving? __________________

At the time of impact, how fast was the other vehicle moving? ___________________

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
- other _________________________________
- spun around
- spun around and hit a stationary object
- hit a stationary object

Did you lose consciousness during the accident? □ No □ Yes

What kind of headrest was in your vehicle?

□ movable fixed headrest □ nonmovable fixed headrest □ no headrest

Where was the headrest positioned on your head? ________________________________

Did you have your seatbelt on during the accident? □ No □ Yes

Did you slide out of your seatbelt during the accident? □ No □ Yes

*Continued….*

How was your torso positioned during the accident? ___________________________________________________

How were your hands positioned during the accident? _____________________________________________________

Did your head hit anything during the accident? -no - yes, please describe__________________________________

Did your face hit anything during the accident? -no - yes, please describe___________________________________

Did your shoulders hit anything during the accident? -no - yes, please describe______________________________

Did your neck hit anything during the accident? -no - yes, please describe___________________________________

Did your chest hit anything during the accident? -no - yes, please describe__________________________________

Did your hips hit anything during the accident? -no - yes, please describe___________________________________

Did your knees hit anything during the accident? -no - yes, please describe__________________________________

Did your feet hit anything during the accident? -no - yes, please describe____________________________________

Did you go to the hospital? If no, skip the following questions.

How did you get to the hospital? _____________________________________

What was the name of the hospital? ______________________________

Were you hospitalized over night? □ No □ Yes

Circle what you were prescribed at the hospital

- pain medication - muscle relaxors - neck brace - other __________________________

Did you receive any stitches for any cuts at the hospital? □ No □ Yes

Were x rays or other tests done at the hospital? If yes, what were they? _____________________________

_________________________________________________________________________________________

Please list and date the other doctors that have treated you. _______________________________________________

Please list and date any diagnostic tests that were performed (i.e. MRI, Cat Scan, EMG, etc.) ___________________

_______________________________________________________________________________________________

Please list and date any previous injuries or accidents. _____________________________________________________

Are you currently receiving treatment for your injuries? If yes, what treatment(s)? ____________________________

_______________________________________________________________________________________________