OLSON CHIROPRACTIC CLINIC
AUTOMOBILE ACCIDENT HISTORY

Name_____ Age_____ Date of Birth_____ ❑ Male ❑ Female

Address_____

City_____ State_____ Zip_____

SS#_____ Driver's Lic. # _____

Insurance company _____

Address of insurance company _____

Have you retained an attorney? ❑ Yes ❑ No Name and address of attorney _____

_____

GENERAL SYMPTOMS

Did you hit any 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 were you taken after the accident?_____

Were you hospitalized? ❑ Yes ❑ No If "Yes," for how long? _____

Did you receive care from any other health care specialist? ❑ Yes ❑ No If "Yes," what is the specialist's name?

_____

What type of care were you given and for how long? _____

Where did you feel the pain? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? ❑ Yes ❑ No If "Yes," how and when? _____

_____

ACCIDENT HISTORY

Date of accident_____ Time of accident_____ ❑ A.M. ❑ P.M.

State how accident happened in your own words _____

_____

_____

What type of vehicle were you in? Make_____ Year_____

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

❑ Passenger ❑ Front ❑ Back ❑ Right side ❑ Left side Were you rotated in seat? ❑ Yes ❑ No

Were you reclined? ❑ Yes ❑ No Other_____

Other people in car? ❑ Yes ❑ No Names and addresses_____

_____

Were they injured? ❑ Yes ❑ No If "Yes," please explain_____

_____

(over)

ACCIDENT HISTORY (continued)

Seat belts on? ❑ Yes ❑ No Shoulder harness on? ❑ Yes ❑ No Position of headrest_____

Was it? ❑ Daylight ❑ Night ❑ Dusk ❑ Dawn What were the weather conditions? _____

Were you tired? ❑ Yes ❑ No Were you awake? ❑ Yes ❑ No How long had you been in the car?_____

Where were you prior to the accident? _____

What were the traffic conditions?_____ What was the posted speed limit?_____

How fast were you going?_____ Type of road: ❑ 2 Lane ❑ 4 Lane ❑ Gravel ❑ Tar

Did it happen at a/an ❑ Stop sign ❑ Traffic light ❑ Intersection ❑ Highway

Was your car hit? ❑ Front ❑ Back ❑ Left side ❑ Right side What damage was done to your car?

Inside_____

Outside _____

Other _____

If you struck another car, did you strike it ❑ Front ❑ Back ❑ Side What damage was done to the other car?

Inside_____

Outside _____

In what condition was the vehicle prior to the accident?_____

Do you have pictures of the involved automobile? ❑ Yes ❑ No What type of vehicle was involved in the accident?

❑ Car ❑ Truck ❑ Motorcycle ❑ Other_____ Size and type _____

Was accident report made? ❑ Yes ❑ No Police of: City_____ County_____ State_____

Who was ticketed?_____ For what? _____

Did your vehicle strike anything? ❑ Yes ❑ No If "Yes" ❑ Another car ❑ Sign ❑ Tree ❑ Bridge ❑ Hedge

❑ An embankment ❑ Other_____ Size and type_____

Were you completely conscious after the impact? ❑ Yes ❑ No

Do you remember the impact? ❑ Yes ❑ No Did your vehicle go off the road? ❑ Yes ❑ No

If "Yes," ❑ Into a ditch ❑ An embankment How deep?_____

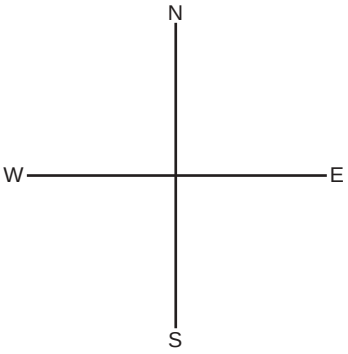
Does it bother you to ride in a car now? ❑ Yes ❑ No If "Yes," as a ❑ Driver ❑ Passenger

State any strange events that happened during or immediately after the accident_____

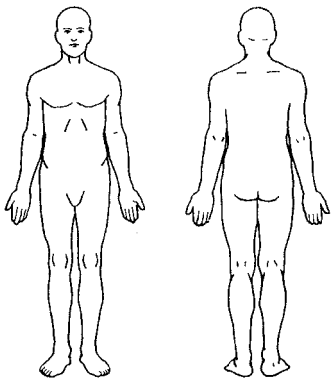
_____

Have you had any time loss from work? ❑ Yes ❑ No If "Yes," from_____ to_____

Have you had to have any outside help? ❑ Yes ❑ No What type?_____



PLEASE DRAW THE ACCIDENT



MARK PAIN AREA

+++	Burning
000	Stabbing
- - -	Sharp
| | |	Constant

Patient Signature _____ Date _____ Staff Signature _____