We Care Chiropractic Center
Helping to improve your quality of life since 1985!

Auto / Crash Information Form

Name: _____ **Date:** _____
Case #: _____ Sex: M F

1) Date and time of crash: _____

2) Location of crash: _____

3) What was your Position in the vehicle? Driver Passenger Backseat

4) What was your vehicle type? _____

5) What was the other vehicle type? _____

6) What was your vehicle doing at the time of the crash?

Stopped at an intersection Making a right turn Stopped at a light Parking
Stopped in Traffic Making a left turn Accelerating Constant speed

7) What was the visability at the time of the accident?

Good Fair Poor

8) What were the road conditions?

Icy Wet Sandy/Rocky Clear and Dry

9) What was your speed? _____ 10) What was their speed? _____

11) What was the point of impact?

Head on Right side Right front Right rear
Back end Left side Left front Left rear

12) Was there another collision? Yes No

If so what was the point of impact?

Head on Right side Right front Right rear
Back end Left side Left front Left rear

13) Did you see the accident coming? Yes No

14) Did you brace for impact? Yes No

15) What did you use to brace? Hands Feet Both

16) Did you have your hands on the steering wheel? Right Hand Left Hand Both Neither

If so, did you hold on or let go at impact? _____

17) Did you have a seat belt on? Yes No

18) Did you have a shoulder Harness on? Yes No

19) What direction was your head facing at the moment of the accident?

Facing forward Turned right Turned left

20) What was the position of your headrest at the time of the accident?

No Headrest Even with the top of head Even with the bottom of head Mid-neck

21) Did your head hit anything the inside of the vehicle? Yes No

If so, where? _____

_____

22) Did you loose consciousness during the injury? Yes No

If so, for how long? Couple Minutes Couple hours Not Sure

23) Did any other body part hit anything the inside of the vehicle? Yes No

If so, what and where? _____

_____

24) Did the seat bend or break? Yes No

25) Does your vehicle have airbags? Yes No

If yes, did they "go off"? Yes No Which ones? Driver Passenger Side

26) Did you feel dazed and confused after the crash? Yes No

27) Did you feel nauseated after the crash? Yes No

28) Were there any cuts and/or bruises after the crash? Yes No

If so, where? _____

29) At the scene of the crash what symptoms did you have? _____

_____

30) Did the police show up? Yes No

31) Was accident report filled out? Yes No

32) Where did you go after the accident? Home Work Hospital ER Private Dr.

33) How did you get there? Drove self Someone else Ambulance Police

34) Have you gone to the hospital since the accident? Yes No

a) What hospital? _____

b) How long after the accident did you go to the hospital? _____

c) Were you admitted? Yes No

d) If so, for how long? _____

e) Were X-rays taken? Yes No Where? _____

f) Was a diagnosis given? Yes No What was it? _____

35) How did your symptoms change later that day (within 12 hours of crash)?

Same Worse Noticed more Symptoms: _____

36) Did you take any medication? Yes No

Over the counter: _____ Prescribed: _____

37) What are your symptoms now? (Please list in order of severity)

1) _____

2) _____

3) _____

4) _____

5) _____

38) Have you missed work? Yes No

If so, how much? _____

39) Was there anyone else in the car with you? Yes No