

# BEACH CITIES --- CHIROPRACTIC

**Confidential Vehicle Accident Report** (please print)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status \_\_ S \_\_ M \_\_ W \_\_ D Children \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Driver's License Number \_\_\_\_\_ Driver's License Issuing State \_\_\_\_\_

**Accident Information**

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ a.m. / p.m.

Were you: (a) Driver \_\_\_\_ (b) Passenger (front) \_\_\_\_ (c) Passenger (rear) \_\_\_\_ (d) Pedestrian \_\_\_\_

Were you wearing a seatbelt? Yes No Did your airbags deploy? Yes No

Your Vehicle: Auto Truck Van Motorcycle Motor Home Bicycle Other \_\_\_\_\_

Year and Model of the Vehicle \_\_\_\_\_ Vehicle Owner \_\_\_\_\_

What was the approximate damage done to the car you were in? \_\_\_\_\_

Was it driveable? Yes No Number of Passengers in your vehicle \_\_\_\_\_

Other Vehicle: Auto Truck Van Motorcycle Motor Home Bicycle Other \_\_\_\_\_

Visibility at time of accident (circle one): poor fair good

Road Conditions at time of accident (circle one): dry wet rainy snow ice fog clear dark

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

How accident occurred:

(a) Struck by another vehicle (b) Struck another vehicle (c) Struck stationary object (d) other

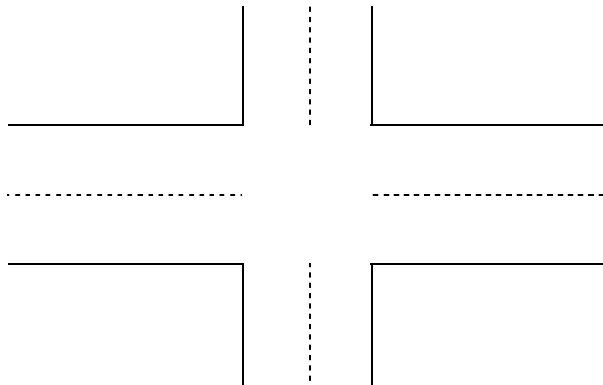
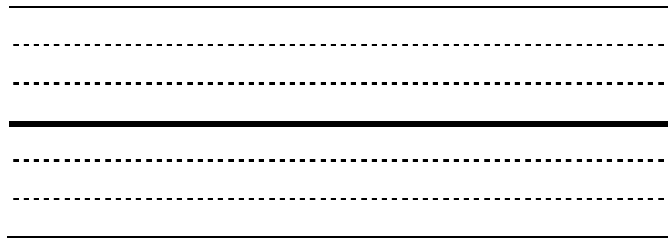
Where was your vehicle hit (circle all applicable): (a) Front (b) Rear (c) Right Side (d) Left Side

Other vehicle contact (circle all applicable): (a) Front (b) Rear (c) Right Side (d) Left Side

In your own words, describe the accident \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Indicate on Appropriate Diagram How the Accident Happened**



**Did you see the accident coming?** Yes No **Did you brace for impact?** Yes No

**Were you pre-warned that the accident was about to happen?** Yes No

**Did your car have headrests?** Yes No If yes, what was the position of those headrests compared to your head before the accident? \_\_\_ Top of headrest even with bottom of head \_\_\_ Top of headrest even with top of head \_\_\_ Top of headrest even with middle of neck

**Was the care you were in braking?** Yes No

**Your approximate speed** \_\_\_\_ mph **Other vehicle's approximate speed** \_\_\_\_ mph

**What occurred at the moment of impact?** (circle all applicable)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

- (a) Tensed body for impact    (b) Neck whipped forward and back    (c) Thrown over seat  
(d) Spine torqued/twisted    (e) Thrown from side to side    (f) Pinned in vehicle  
(g) Thrown from vehicle    (h) Cut and bruised    (i) Other \_\_\_\_\_

**What was your head position at the time of impact?**

Head turned:    \_\_\_ Right    \_\_\_ Left    \_\_\_ Looking Back    \_\_\_ Straight Ahead  
Body rotated:    \_\_\_ Right    \_\_\_ Left

**Did you strike your:** (circle all applicable)

- Head**            **On:** Dashboard    Windshield    Steering Wheel    Rt Door    Lt Door    Headrest    Other  
**Shoulder**        **On:** Dashboard    Windshield    Steering Wheel    Rt Door    Lt Door    Headrest    Other  
**Arm**             **On:** Dashboard    Windshield    Steering Wheel    Rt Door    Lt Door    Headrest    Other  
**Elbow**           **On:** Dashboard    Windshield    Steering Wheel    Rt Door    Lt Door    Headrest    Other  
**Wrist**            **On:** Dashboard    Windshield    Steering Wheel    Rt Door    Lt Door    Headrest    Other  
**Hip**              **On:** Dashboard    Windshield    Steering Wheel    Rt Door    Lt Door    Headrest    Other  
**Knee**             **On:** Dashboard    Windshield    Steering Wheel    Rt Door    Lt Door    Headrest    Other  
**Ankle**            **On:** Dashboard    Windshield    Steering Wheel    Rt Door    Lt Door    Headrest    Other

Were you rendered unconscious?    Yes    No

Were you able to move all your body parts?    Yes    No    If no, explain \_\_\_\_\_

Were you able to get out of the car unaided?    Yes    No    If no, explain \_\_\_\_\_

Did you bleed or get cuts and bruises?    Yes    No    If yes, explain \_\_\_\_\_

Were there any flying objects in the car?    Yes    No    If yes, explain \_\_\_\_\_

Please describe how you felt:

**DURING** the accident: \_\_\_\_\_

**IMMEDIATE AFTER** the accident: \_\_\_\_\_

**LATER THAT DAY:** \_\_\_\_\_

**THE NEXT DAY:** \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Headache       | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Light bothers eyes  | <input type="checkbox"/> Cold sweats   |
| <input type="checkbox"/> Neck pain      | <input type="checkbox"/> Head heavy      | <input type="checkbox"/> Loss of memory      | <input type="checkbox"/> Feet cold     |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Ears Ring       | <input type="checkbox"/> Pins/Needles (arms) | <input type="checkbox"/> Hands cold    |
| <input type="checkbox"/> Mid back pain  | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Pins/Needles (legs) | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Low back pain  | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Sleeping problems   | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Face flush     | <input type="checkbox"/> Nervousness     | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Tension        | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vomit         |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Chest pain      | <input type="checkbox"/> Numbness in toes    | <input type="checkbox"/> Fainting      |
| <input type="checkbox"/> Loss of smell  | <input type="checkbox"/> Fever           | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Fatigue       |

Symptoms other than above \_\_\_\_\_  
\_\_\_\_\_

**PAIN LEVEL** On a scale of 0 – 10, with 0 being pain free and fully functional, and 10 being constant agony and total inability to function, where would you rate yourself?

\_\_\_\_\_

No Pain 0    1    2    3    4    5    6    7    8    9    10 Excruciating Pain

**INDICATE YOUR INABILITY TO PERFORM THE FOLLOWING ACTIVITIES**

U= Unable    P= Painful    D= Difficult    L= Limited    N= Normal

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Coughing or sneezing   | <input type="checkbox"/> Lying on side    | <input type="checkbox"/> Gripping        | <input type="checkbox"/> Getting in/out of car |
| <input type="checkbox"/> Bending forward        | <input type="checkbox"/> Pushing          | <input type="checkbox"/> Pulling         | <input type="checkbox"/> Climbing stairs       |
| <input type="checkbox"/> Bending to brush teeth | <input type="checkbox"/> Kneeling         | <input type="checkbox"/> Reaching        | <input type="checkbox"/> Turning over in bed   |
| <input type="checkbox"/> Walking short distance | <input type="checkbox"/> Balancing        | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Dressing self         |
| <input type="checkbox"/> Standing over 1 hour   | <input type="checkbox"/> Stooping         | <input type="checkbox"/> Lying on back   | <input type="checkbox"/> Sleeping              |
| <input type="checkbox"/> Lying on stomach       | <input type="checkbox"/> Sitting at table | <input type="checkbox"/> Other: _____    |  |

Have you lost any time from work as a result of this accident? Yes No

. If yes, Last day worked: \_\_\_\_\_

. Type of employment: \_\_\_\_\_

. Are you being compensated for time lost from work? Yes No

Was a Police report filed? Yes No

Did you receive medical attention at the scene of the accident? Yes No

If yes, what was done? \_\_\_\_\_

Were you taken by ambulance to the hospital? Yes No If yes, where? \_\_\_\_\_

What was done? \_\_\_\_\_

What was the diagnosis given? \_\_\_\_\_

Were you x-rayed? Yes No If yes, what area? \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Have you received any other care for this accident? Yes No

Did you have any physical complaints before the accident? Yes No

If yes, please describe: \_\_\_\_\_

Have you ever been involved in an accident before? Yes No

If yes, please describe and indicate date: \_\_\_\_\_

List surgical operations and year: \_\_\_\_\_

Drugs you now take: None Nerve Pain Killers Muscle Relaxers Birth Control Pills  
Tranquillizers Insulin Other \_\_\_\_\_

Do you smoke? Yes No If yes, how many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, how many drinks per week? \_\_\_\_\_

Do you consume caffeine? Yes No If yes, how many cups per day? \_\_\_\_\_

Do you exercise regularly? Yes No If yes, what exercises? \_\_\_\_\_

During the day (at work or at home) do you: sit computer work desk work stand in  
one position lift items greater than 25 lbs lift items less than 25 lbs

Have you ever suffered from: Y or N

\_\_\_ Dizziness \_\_\_ Backaches \_\_\_ Headaches \_\_\_ Diabetes

\_\_\_ Arthritis \_\_\_ Heart Trouble \_\_\_ Asthma \_\_\_ Digestive Disorders

\_\_\_ Nervousness \_\_\_ Sinus Trouble \_\_\_ Neck Pain

**Authorization for Release of Medical Information and Assignment of Benefits**

I authorize Beach Cities Chiropractic to release medical information for insurance purposes concerning my treatment. I assign my rights of benefits to Beach Cities Chiropractic.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand and agree that the doctors of Beach Cities Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history, the conduction of a physical examination, and the conduction of X-Rays are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_