Patient: _____ Date: _____

History of Accident

Date of accident: _____ Time: _____ Location: _____
Type of accident: (circle answer) Motor Vehicle Accident Slip and Fall Other:_____

The patient was: (circle answer)
Driver / Front Passenger / Back Passenger: (Left , Middle, Right, Back Row)

Were you wearing your seatbelt? YES or NO

DESCRIPTION OF ACCIDENT:
__ Stopped/slowing for red light/traffic, struck from behind __caused to hit auto in front of you.
__ Side Swiped by another vehicle traveling is the same direction/ different direction
__ Head – on collision
__ Vehicle was struck causing it to spin/ roll over.
__ You were thrown from the vehicle
__ Other _____

Was police report filed? _____ Do you have a copy? _____

Did you body strike any objects:

__ Windshield	__ Headrest	__ Dash Board
__ Steering Column	__ Door Frame	__ Rear View Mirror
__ Back of Seat	__ Seat Broke	__ Jarred or Thrown
__ Cannot remember	__ Unconscious	

__ Other_____
Did airbag inflate? YES or NO
Was there a loss of consciousness? YES or NO
Are you experiencing headaches since the accident? YES or NO Constant or Intermittent?

Point of Impact:

__ Head	__ Face	__ Chest	__ Neck
__ Back	__ Arm L/R	__ Shoulder L/R	__ Legs L/R
__ Knee L/R			

Were you taken to the hospital? _____ If so, where _____
What type of transportation? _____
Did the hospital: X-ray_____Prescribe medication _____ Other: _____
Did you go to any other provider to seek care and what was it?
_____

Your Current Work Status:
Have you lost time from work since the accident? _____ If so, when was the last date that you were able to work?
_____ Are you still off work? _____
What type of work do you perform? _____
Are your work activities restricted as a result of this injury? _____

Patient Signature _____ Date:_____

Dr. Timothy Lanier D.C._____ Date:_____