McCormack Chiropractic, S.C.
Automobile Accident History Form

Your Name: _____ Today's Date _____

Date of Accident: _____ Time of Accident: _____ am / pm

City of Accident: _____ Street of Accident: _____

Road conditions at time of Accident: WET DRY ICY OTHER _____

Did the police come to the accident scene? YES NO ; Is there a report ? YES NO

Did you go to the hospital? YES NO
If yes, what is the name and city of the hospital? _____
How did you get to the hospital? _____
What parts of your body were x-rayed at the hospital? _____
What did the hospital do for your injuries? _____
How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____
What bruises did you receive during the accident? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?
AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO; How long _____

Did you experience a flash of light or explosion in your head? YES NO

From the accident did you become (please circle) :

CONFUSED	DISORIENTED	LIGHT HEADED	
DIZZY	NAUSEATED	BLURRED VISION	RING/BUZZ IN EARS

If you still have any of these symptoms, which ones? _____

Are you currently suffering from any of the following (please circle):

RESTLESSNESS	IRRITABLE	NUMBNESS
DIFFICULTY CONCENTRATING	MEMORY PROBLEMS	FEEL HOT
SLEEPLESSNESS	FORGETFULNESS	FEEL COLD

How far is the top of the headrest or seatback from the top of your head?
(approximately): _____ inches above or below

Were you wearing a seatbelt? YES NO
If yes, was it a lap seatbelt _____ shoulder-lap seatbelt _____
Is there an airbag in your car? YES NO
If yes, frontal or side _____ Did it activate? _____

See Back Side

Please list the make and model of the vehicle you were in:
Year _____ Make _____ Model _____

Was your car stopped at the time of impact? YES NO
If yes, was the driver's foot also on the brake? YES NO
If no, the estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it:
Slowing down? YES NO
Gaining speed? YES NO
Traveling at a steady rate of speed? YES NO

On what part of the automobile did the following body parts hit?
Head hit _____ Chest Hit _____
Right/left shoulder hit _____ Right/Left arm hit_____
Right/left hip hit _____ Right/Left leg hit _____
Right/left knee hit _____ Other _____

Did you receive any injury or bruise from the seatbelt? YES NO
If yes, please describe: _____

Which of the following car parts broke during the accident? (please circle)
Windshield Front seat
Right/left side window Back seat
Steering wheel

Was your chest pointed straight forward at the time of the collision?
YES NO; If no, how was it turned? _____

Was your head pointed straight forward? YES NO
If no, what direction was it turned and by how much? _____

What is the year, make and model of the other vehicle?
Year _____ Make _____ Model _____

Was the other vehicle moving at the time of the collision? YES NO
If yes, What was its approximate speed? _____

If the other vehicle was moving at the time of the collision, was it (please circle):
Slowing down gaining speed traveling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

_____

_____

_____

_____