VEHICLE ACCIDENT INFORMATION

Lyon County Chiropractic
Dr. Cody Hoefert, DC Dr. Nick Weber, DC Dr. Marji deBoer, DC
909 S. Union St.
Rock Rapids, IA 51246
712-472-4732

PATIENT INFORMATION

Date:_____

Patient Name_____

Date of Accident_____Time of Accident_____ am / pm

Please describe the accident in your own words_____

_____

_____

_____

Were you the: □Driver □Front Passenger □Rear Passenger □Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving Conditions □Dry □Wet □Icy □Other_____

Which direction were you headed?_____

Speed you were traveling_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? □ Yes □ No
If yes, what type? □ Lap □ Shoulder

Was vehicle equipped with airbags? □ Yes □ No
If yes, did it/they inflate properly? □ Yes □ No

Did your seat have a headrest? □ Yes □ No

If yes, what was the position of the headrest?
□ Low □ Midposition □ High

OTHER VEHICLE
(If applicable)

Make and model_____

Which direction was other vehicle headed?_____

Speed of other vehicle_____

IMPACT

Did your car impact another vehicle? □ Yes □ No

Did your car impact a structure? □ Yes □ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?
□ Yes □ No If yes, explain_____

Was impact from:
□ Front □ Rear □ Left □ Right □ Other_____

At the time of impact were you:
□ Looking straight ahead □ Looking to the right
□ Looking to the left □ Looking down
□ Looking up

Were both hands on the steering wheel? □ Yes □ No
If no, which hand was on the wheel? □ Right □ Left

Was your foot on the brake? □ Yes □ No
If yes, which foot was on the brake? □ Right □ Left

Were you: □ Surprised by impact
□ Braced for impact

POLICE

Did the police come to the accident site? □ Yes □ No
Were there any witnesses? □ Yes □ No
Was a police report filed? □ Yes □ No
Was a traffic violation issued? □ Yes □ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? □ Yes □ No If yes, for how long?_____

Please describe how you felt immediately after the accident:_____

_____

_____

TREATMENT

Did you go to the hospital? □ Yes □ No
When did you go? □ Immediately after accident □ Next day □ 2 days or more after the accident
How did you get to the hospital? □ Ambulance □ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since the injury? □ Yes □ No How many work days have you missed?_____
Prior to the injury, were you able to work on an equal basis with others your age? □ Yes □ No
If you have had any of the following symptoms since your injury, please check:

□ Arm/shoulder pain	□ Feet/toe numbness	□ Neck pain
□ Back pain	□ Hand/finger numbness	□ Neck stiff
□ Back stiffness	□ Headaches	□ Shortness of breath
□ Chest pain	□ Irritability	□ Sleep difficulty
□ Dizziness	□ Jaw problems	□ Stomach upset
□ Ear buzzing	□ Leg pain	□ Tension
□ Ear ringing	□ Memory loss	□ Vision blurred
□ Fatigue	□ Nausea	

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

□ Sharp	□ Dull	□ Throbbing	□ Numbness
□ Aching	□ Shooting	□ Burning	□ Tingling
□ Cramps	□ Stiffness	□ Swelling	□ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful:

□ Sitting	□ Standing	□ Walking
□ Bending	□ Lying Down	

I certify that the above is correct to the best of my knowledge_____