Valley Chiropractic:
A Creating Wellness
Center

Automobile Injury History Form

1. What was the date of injury? _____
2. What time did the accident occur? _____
3. How many vehicles were involved? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What street or intersection were you on when the intersection occurred? _____

_____

6. What direction were you traveling? _____
7. What city did the accident occur? _____
8. What state did the accident occur in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? If yes please describe. _____

_____

11. Where were you sitting in the vehicle during the accident? _____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vechicle moving? _____
16. At the time of the impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight	-spun around
- kept going straight hitting another car	- spun around and hit stationary object
- was hit by another vehicle	- hit stationary object

18. Did you lose consciousness during the accident? Yes No
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How was your hands positioned during the accident? _____
22. Did your head hit anything during the accident? No Yes, please describe _____
23. Did your face hit anything during the accident? No Yes, please describe _____
24. Did your shoulders hit anything during the accident? No Yes, please describe _____

25. Did your neck hit anything during the accident? No Yes, please describe _____

26. Did your chest hit anything during the accident? No Yes, please describe _____

27. Did your hips hit anything during the accident? No Yes, please describe _____

28. Did your knees hit anything during the accident? No Yes, please describe _____

29. Did your feet hit anything during the accident? No Yes, please describe _____

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- non-movable fixed headrest
- no headrest

31.Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the wreck? _____

33. Did you slide out of your seatbelt? _____

34. Did your airbags deploy? Yes No

35. What was damaged in your vehicle? (circle all that apply)

- windshield	- rear bumper	- mirror
-steering wheel	-front bumper	-knee bolster
- dashboard	-trunk	- back right door
- seat frame	- front left door	- completely totaled
-side window	-front right door	
-rear window	-back left door	

36. Choose the items dented inward?

-floorboards -side door -dashboard

37. Choose the doors that would not open as a result of the accident?

-front left -front right
- rear left - rear right

38. Did you got to the hospital? Yes No (if no, you are done!)

39. How did you get the hospital? _____

40. What was the name of the hospital? _____

41. Were you hospitalized over night? Yes No

42. Circle what you were prescribed at the hospital?
-pain medication -muscle relaxers -neck brace

43. Did you receive any stitches for any cuts at the hospital? _____

44. Were X-rays taken at the hospital? If yes, which area was taken? _____

45. Any specialized Imaging performed? MRI CT Other: _____