# Dekalb Chiropractic Center, inc.

## AUTOMOBILE ACCIDENT

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**Patient Name**______________________________________

**Today's Date**______________________________________

**Date of Accident**_____/ _____/ _____

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**Patients Relative Speed At Impact _____MPH (your speed + their speed if head-on; their speed – your speed if rear-ended)**

**Patients Speed Was? Stopped Accelerating Constant Speed Slowing**

**Head Restraints? UP Down Integral to the Seat None Present Don't Know**
**Site of Impact? ____________________________________________________**

**Your Vehicle Was A? Subcompact Compact Mid-Size Small Truck Full Truck**
**Van mini / full Tractor-Trailer Other_________________**

**Your Position In The Car Was? Driver Passenger RR Passenger LR Passenger**

**Other Car Was A? Subcompact Compact Mid-Size Small Truck Full Truck**
**Van mini / full Tractor-Trailer Other__________________**

**Where Was Your Car Struck? Front Rear R-Side L-Side R-Front Corner**
**L-Front Corner R-Back Corner L-Back Corner Other__________________________**

**Were Your Seatbelts On At The Time Of Impact? Yes No Unknown**

**Were The Brakes Applied At The Time Of Impact? Yes No Unknown**

**Did The Airbags Deploy At The Time Of Impact? Yes No Unknown**

**Did The Seat Break At The Time Of The Impact? Yes No Unknown**

**Drivers Hand Position on Wheel? Left Hand Right Hand Both Hands Cannot Recall**

**Were You Wearing Head Apparel? No Yes (Hat Glasses Both Neither)**

**Was the Head Apparel Knocked Off? Yes No**

**Location Of Accident:** _________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Body Position At Impact? Upright Leaning Forward Turned R/L cannot recall**

**Head Position At Impact? Not turned Turned to the left Turned to the right Cannot recall**

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**Were You Aware Of The Impact Prior To? Yes No**

**Did Any Part Of Your Body Impact The Car?**
**Impacted Object______________________________ Body Part___________________________**
**Impacted Object______________________________ Body Part___________________________**
**Impacted Object______________________________ Body Part___________________________**

**Where Did You Go After The Accident? Work Home Hospital Family Doctor**
**Other____________________________________**

**If You Sought Medical Care, Where Did You Go?_____________________________________**

**If You Sought Medical Care, How Did You Get There? Self Friend Ambulance**
**Helicopter**

**Did You Lose Consciousness At The Time Of The Accident? Yes No**

**Description Of Accident: ____________________________________________________________**
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Do You Have An Attorney? Yes No If Yes, Who____________________________________**