ACCIDENT REPORT

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

Type of Injury: ☐ Auto/ motor vehicle ☐ Work ☐ Slip/ fall ☐ Other: _____

Describe your symptoms in detail: (check all that apply)

1) GENERAL SYMPTOMS:

☐ nervousness ☐ insomnia/ sleep problems
☐ irritability ☐ tension
☐ fatigue ☐ dizziness
☐ depression ☐ mental confusion

2) HEAD:

☐ Headaches: ☐ mild ☐ moderate ☐ severe
how often? _____ times per day / week
are they: ☐ sharp ☐ dull ☐ constant ☐ intermittent
where located:
☐ back of head: ☐ forehead ☐ temples
☐ right side ☐ left side ☐ behind eyes

general:
☐ light headed ☐ sensitivity to light
☐ memory loss ☐ loss of balance
☐ blurred vision ☐ hearing loss
☐ double vision ☐ ringing in the ears

jaw (temporomandibular joint):
pain: ☐ left ☐ right ☐ both
stiffness: ☐ left ☐ right ☐ both
difficulty opening: ☐ left ☐ right ☐ both
difficulty closing: ☐ left ☐ right ☐ both

3) NECK:

☐ Pain: ☐ mild ☐ moderate ☐ severe
where located
☐ back of neck: ☐ front of neck
☐ right side ☐ left side ☐ center
pain increased by:
☐ forward movement
☐ backward movement
☐ rotation of head: right / left
☐ bending of neck: right / left
☐ stiffness
☐ muscle spasm
☐ grinding/ grating sounds

4) SHOULDERS:

pain in joint: ☐ left ☐ right ☐ both
pain across shoulder: ☐ left ☐ right ☐ both
limitation of movement: ☐ left ☐ right ☐ both
tension: ☐ left ☐ right ☐ both

5) ARMS:

upper arm
pain: ☐ left ☐ right ☐ both
pins and needles/ tingle ☐ left ☐ right ☐ both
numbness: ☐ left ☐ right ☐ both
elbow pain: ☐ left ☐ right ☐ both
fore arm
pain: ☐ left ☐ right ☐ both
pins and needles/ tingle ☐ left ☐ right ☐ both
numbness: ☐ left ☐ right ☐ both

6) HANDS:

wrist pain: ☐ left ☐ right ☐ both
hand
pain: ☐ left ☐ right ☐ both
pins and needles/ tingle ☐ left ☐ right ☐ both
numbness: ☐ left ☐ right ☐ both

7) MIDBACK:

pain: ☐ left ☐ right ☐ both
☐ mild: ☐ moderate ☐ severe
spasm ☐ left ☐ right ☐ both
☐ mild: ☐ moderate ☐ severe

8) CHEST:

chest pain: ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe
rib pain ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe
☐ shortness of breath
☐ irregular heartbeat

9) LOW BACK:

pain: ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

spasm: ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

10) ABDOMINAL SYMPTOMS:

pain	☐ mild	☐ moderate	☐ severe
nervous stomach	☐ mild	☐ moderate	☐ severe
nausea	☐ mild	☐ moderate	☐ severe
gas	☐ mild	☐ moderate	☐ severe
constipation	☐ mild	☐ moderate	☐ severe
diarrhea	☐ mild	☐ moderate	☐ severe
heartburn	☐ mild	☐ moderate	☐ severe
indigestion	☐ mild	☐ moderate	☐ severe
loss of appetite	☐ mild	☐ moderate	☐ severe

11) HIPS AND LEGS:

pain in buttocks ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

pain in hips ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

pain down leg(s) ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

knee pain ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

leg cramp ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

12) FEET:

ankle pain/ swelling ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

foot pain / cramps ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

numbness / swelling ☐ left ☐ right ☐ both
☐ mild ☐ moderate ☐ severe

Where did the accident happen, in detail:_____

_____

Did weather (ice, snow, rain, lightning, etc.) play a part in the accident?:_____

Have you seen another doctor or health care provider for these symptoms? YES NO If yes, name and address:

_____

For the present injury, have you missed any work?: YES: NO If yes, dates missed:_____

_____

Were you the: ☐ driver ☐ passenger, front seat ☐ passenger, back seat ☐ driver's side ☐ passenger side ☐ pedestrian

Were you wearing a seat belt? YES NO

Type of vehicle you were in: auto truck van motorcycle motorhome bicycle ☐ other:_____

Other vehicle involved: auto truck van motorcycle motorhome bicycle ☐ other:_____

How accident occurred: ☐ struck BY another vehicle ☐ struck another vehicle ☐ struck a stationary object ☐ other:_____

Where was your vehicle damaged: front rear right side left side left front right front left rear right rear

What occurred at the moment of impact? (check as many as apply)

☐ tensed body for impact ☐ neck whipped forward and back ☐ spine torqued and twisted

☐ thrown from vehicle ☐ pinned in vehicle ☐ thrown from side to side

☐ thrown over seat ☐ cuts and bruises ☐ struck a part inside the vehicle

Did you strike your (circle as many as apply):

HEAD against: dashboard windshield steering wheel right door left door seat frame other:_____

CHEST left / right dashboard windshield steering wheel right door left door seat frame other:_____

SHOULDER left / right dashboard windshield steering wheel right door left door seat frame other:_____

ARM left / right dashboard windshield steering wheel right door left door seat frame other:_____

ELBOW left / right dashboard windshield steering wheel right door left door seat frame other:_____

WRIST left / right dashboard windshield steering wheel right door left door seat frame other:_____

HIP left / right dashboard windshield steering wheel right door left door seat frame other:_____

KNEE left / right dashboard windshield steering wheel right door left door seat frame other:_____

ANKLE left / right dashboard windshield steering wheel right door left door seat frame other:_____

Other:_____ left / right dashboard windshield steering wheel right door left door seat frame other:_____

Were you rendered unconscious? YES NO Did you receive medical attention at the scene? YES NO

Where did you go immediately following the accident? home hospital MD Chiropractor work resumed regular activities

Comments:_____

_____

By signing below, I acknowledge that the information given above is true to the best of my knowledge.

Signature:_____ Date:_____