AUTO ACCIDENT REPORT

Date: _____ Social Security #: _____

Name: _____ _____ _____
(First Name) (Last Name) (Middle Initial)

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Telephone: _____ _____ _____
(Home) (Work) (Cell)

Email: _____

Emergency Contact: _____ _____ _____
(Name) (Relationship) (Phone Number)

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ Spouse's DOB: _____ Number of Children: _____

Occupation: _____ ☐ Full time ☐ Part time ☐ Student ☐ Retired

Employer / School: _____

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

THE ABOVE PATIENT ALLEGES HIS/HER PRESENT CONDITION IS DUE TO AN ACCIDENT DESCRIBED BELOW:

Date of the accident: _____ Approximate Time: ☐ AM ☐ PM

I was: ☐ The Driver ☐ A Passenger I was seated: ☐ In Front ☐ In Back ☐ Other _____

The vehicle I was in: ☐ Car ☐ Truck ☐ Other _____ Location: ☐ Road or ☐ Highway

My vehicle was: ☐ Stopped ☐ Moving My vehicle was facing: ☐ North ☐ South ☐ East ☐ West

My vehicle was damaged: ☐ Rear ☐ Front ☐ Left ☐ Right

At the time of the collision, I was Looking: ☐ Forward ☐ Up ☐ Down ☐ Left ☐ Right

At the time of the collision, I was: ☐ Bending Down ☐ Turning to the Left ☐ Turning to the Right

Due to the impact, I was thrown: ☐ Backward ☐ Forward ☐ To the Left ☐ To the Right

Part of body struck _____

Part of car my body struck against: ☐ Steering ☐ Wheel ☐ Dashboard ☐ Windshield ☐ Other _____

Part of my body injured _____

Injury _____

I was wearing a seat belt: ☐ Y ☐ N

I was rendered unconscious: ☐ Y ☐ N

I was able to get out and walk from the vehicle unattended: ☐ Y ☐ N

I went: ☐ Home ☐ Hospital ☐ Other _____

I left in: ☐ My Vehicle ☐ Another Vehicle ☐ Ambulance ☐ Police Vehicle

After the collision, I: ☐ Rested ☐ Was Examined ☐ Other _____

I stayed in the hospital: ☐ Y ☐ N

ABSOLUTE HEALTH CHIROPRACTIC
95 CLIFTWOOD DRIVE NE ♦ SUITE C ♦ SANDY SPRINGS, GA 30328
404-257-0188 ♦ askdrcathy@clear.net ♦ www.dr-cathy.com

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I received treatment: ☐ Y ☐ N If yes, treatment consisted of _____

That night I was: ☐ Restless ☐ Painful ☐ Uneventful

The following day, I felt: ☐ Better ☐ Worse ☐ The Same

I experienced: ☐ Relief ☐ Pain ☐ Numbness ☐ Aching in the region of _____

I missed work: ☐ Y ☐ N If yes, dates *from* _____ *to* _____ On my job as _____

My present condition has: ☐ Interfered with ☐ Lessened ☐ Eliminated the ability to do the following

_____

_____

PREVIOUS DOCTORS

DR: _____ Date: _____ For: _____

DR: _____ Date: _____ For: _____

DR: _____ Date: _____ For: _____

PAST MEDICAL HISTORY

Significant Illnesses: _____

_____

Significant Accidents: _____

_____

Operative Procedures: _____

_____

Medications Taken: _____

_____

Other Known Abnormalities: _____

_____

OCCUPATIONAL HISTORY

Regular occupation is _____

Number of months or years at present occupation _____

Does the job require: ☐ Standing ☐ Sitting ☐ Walking ☐ All (*Standing, Sitting & Walking*)

How many hours do you work at present occupation? _____

Does the job require lifting? ☐ Y ☐ N If yes, describe _____

What are the maximum pounds that you lift per item? _____

Is help available for lifting? ☐ Y ☐ N

Does the job require full movement of: ☐ Arms ☐ Legs ☐ Both (*Arms & Legs*)?

Do you smoke? ☐ Y ☐ N If yes, how many packs per week? _____

Have you smoked in the past? ☐ Y ☐ N If yes, when did you quit? _____

Do you consume alcohol? ☐ Y ☐ N If yes, how many drinks per week? _____ Type _____

Patient Signature: _____ **Date:** _____

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