Quality of Life Chiropractic
6910 FM 1488 Suite 3; Magnolia, TX 77354; 281-789-4182
17099 Walden Rd Suite 100; Montgomery, Tx 77356; 936-703-2610

Patients Name: _____

Today's Date: _____

Accident Information

Date of Accident: _____ Time of Accident: _____

Name of the location/street on which you were traveling: _____

Make & Model of the vehicle you were occupying: _____

Where you the: ☐ Driver ☐Front Passenger ☐Rear Passenger Were you wearing your seatbelt? ☐Yes ☐ No

Was this vehicle equipped with airbags ☐Yes ☐ No Did the airbags inflate? ☐Yes ☐No

Did the impact to your vehicle come from the: ☐Front (R/L) ☐Rear(R/L) ☐Side(R/L) ☐Other

In relation to the base of you skull, where was the headrest? ☐Above ☐Below ☐At the base

What was your vehicle's movement? ☐Backing up ☐Moving forward ☐Stopped ☐Turning(R/L)

What was the OTHER vehicle's movement? ☐Backing up ☐Moving forward ☐Stopped ☐Turning(R/L)

Where were you looking at the time of impact? ☐Ahead ☐Down ☐Over your shoulder ☐Right ☐Left

Did any part of your body strike anything in the vehicle ☐Yes ☐No (Ex: head, shoulders, neck, low back, midback, wrist/hand, foot/ankle, knee)

If yes, explain what symptoms you were experiencing: _____

_____

Did the accident render you unconscious? ☐ Yes ☐ No If yes, for how long? _____

What was the approximate speed of your vehicle? _____mph Speed of the OTHER vehicle? _____mph

Were you ☐Aware OR ☐Surprised by the impact? What did your vehicle impact? ☐ A Vehicle ☐Other _____

Number of people in the accident? _____ Was your car towed from the accident scene? ☐ Yes ☐ No

What was the damage to your vehicle? ☐Heavily visible ☐Moderately visible ☐Slightly visible ☐None ☐Totaled ☐Unknown

What was the damage the OTHER vehicle? ☐Heavily visible ☐Moderately visible ☐Slightly visible ☐None ☐Totaled ☐Unknown

Names of passengers: _____

- Are the passengers seeking chiropractic care for their injuries? ☐ Yes ☐ No
- Do they have personal injury protection insurance or Attorney helping with their care? ☐Auto Insurance ☐Attorney

In your own words describe the accident: (Ex: weather, visibility, time of day, witlessness, road conditions, vehicles involved, etc.)

_____

_____

Please describe how you felt immediately after the accident: (Ex: scared, frustrated, angry, nervous, confused, indifferent, etc.)

_____

_____

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Legal Information

Did the police come to the accident scene? ☐ Yes ☐ No Was a Police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐Yes ☐No

Was a traffic violation issued? ☐ Yes ☐ No

To whom: _____

Have you retained an attorney? ☐ Yes ☐No

If yes, whom? _____

Attorney Phone Number: _____

Medical Information

Did EMS come to the accident scene? ☐Yes ☐ No How did you leave the accident scene? _____

Have you gone to a hospital or seen any other Doctor? ☐Yes ☐ No When did you go? ☐ Immediately ☐ Next Day ☐ 2+ Days

How did you get there? ☐Ambulance ☐ Private transportation Was Medicine prescribed? ☐Yes ☐No

Name of the hospital and/or attending doctor:_____

Was he/she a: ☐D.D.S ☐M.D. ☐ D.C. ☐ D.O. Were X-ray's taken? ☐Yes ☐ No

Have you been able to work since the injury? ☐ Yes ☐ No Are you restricted as a result of this injury ☐Yes ☐No

Patient Symptoms: Please Circle the Body Parts That Are Involved In the Injury