



WELLNESS FROM THE INSIDE OUT

Family and Sports Chiropractic

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PLEASE PRINT

Name (Last, First, MI)		<input type="checkbox"/> M	<input type="checkbox"/> F	D.O.B.:
VEHICLE ACCIDENT INFORMATION				
Date of Accident:		Time of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM		
Road/Street Name:				
City, State:		Direction You Were Headed:		
Nearest Intersection with Road/Street:				
Driving Conditions: <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Icy <input type="checkbox"/> Other		Speed You Were Traveling:		
Were you the: <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Rear Passenger <input type="checkbox"/> Pedestrian			How Many People Were in the Accident Vehicle:	
Make and Model of the Vehicle You Were In:				
Were You Wearing a Seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, What Type: <input type="checkbox"/> Shoulder Harness <input type="checkbox"/> Lap Belt		
Was Vehicle Equipped with Airbag? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, did it/they inflate properly? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did Your Seat Have a Headrest? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, What was the Position of the Headrest? <input type="checkbox"/> Low <input type="checkbox"/> Mid <input type="checkbox"/> High		
Did Any Part of Your Body Strike the Inside of the Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		Describe:		
Did Your Car Impact Another Vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		Another Structure? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Make and Model of Other Vehicle:		Speed of Other Vehicle:		
Direction of Other Vehicle:				
Was Impact From: <input type="checkbox"/> Rear <input type="checkbox"/> Front <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other				
At the Time of Impact Were You: <input type="checkbox"/> Looking Straight Ahead <input type="checkbox"/> Looking to the Left <input type="checkbox"/> Looking to the Right <input type="checkbox"/> Looking Up <input type="checkbox"/> Down				
Were Both Hands on the Steering Wheel? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Not, Which Hand was on the Wheel?		
Was Your Foot on the Brake? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Were You: <input type="checkbox"/> Surprised By the Impact <input type="checkbox"/> Braced for the Impact				
Did the Police Come to the Accident Site? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was a Report Filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were there any Witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was a Traffic Violation Issued? <input type="checkbox"/> Yes <input type="checkbox"/> No		To Whom?
Describe the Accident in Your Own Words:				
Were you Unconscious After the Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Did You Go to the Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		By Ambulance: <input type="checkbox"/> Yes <input type="checkbox"/> No		Next Day: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Hospital:		Name of Doctor:		
Diagnosis:				
Treatment Received:				
X-Rays Taken:				
Have You Been Able to Work Since the Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Not, How Many Days Have You Missed:		

Patient Signature: _____ Date: _____