Patient Name: _____ Patient Date of Birth: _____

Motor Vehicle Accident Details

Date of Accident: _____ Time of Day: _____

Direction you were headed? □North □East □South □West

Direction of the other vehicle? □North □East □South □West

Where were you struck? □Rear □Front □Drivers Side □Passengers Side

Your position: □Driver □Passenger □Front Seat □Back Seat

Number of people in your vehicle? _____

Number of people in other vehicle? _____

Were you knocked unconscious? □Yes □No

Did you know that you were going to get hit? □Yes □No

Were you wearing a seat belt? □Yes □No

Did airbags deploy? □Yes □No

Were the police notified? □Yes □No

Did an EMT/Paramedic come to the accident? □Yes □No

Did EMT/Paramedic inspect you? □Yes □No

Were you transported via ambulance? □Yes □No

Describe details of the accident: _____

_____

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? □Yes □No Explain: _____

_____

_____

How did you feel as the accident was happening?_____

How did you feel immediately after the accident?_____

How did you feel later that day? _____

How did you feel the next day? _____

Where were you taken after the accident? _____

Have you ever been treated by another doctor since the accident? □Yes □No If yes, what type of treatment did you receive?

_____

Since this injury occurred, are your symptoms: □ Improving □ Staying the same □ Getting Worse

Have you lost time from work as a result of this accident? □Yes □No *(If yes, please answer the following questions)*

a. Last Day Worked: _____ b. Type of Employment: _____

Do you notice any activity restrictions as a result of this injury? □Yes □No If yes, please describe in detail?

_____

_____

I acknowledge that the above details of the accident described above are complete and accurate, and that if any changes in my health occur I will discuss these changes with the Doctors at JayMac Chiropractic.

_____ _____ _____ _____

Patient Signature *or* Parent/Guardian (if a minor) Date Signature of Doctor Date

_____

Printed Name of Patient *or* Parent/Guardian (if a minor)