

**Schneider Chiropractic
Supplemental Personal Injury / Automobile Accident Form (1)**

Name _____ Today's Date: ____/____/____

At time of accident: Employer: _____ Work phone # _____

Current employer? _____ Unemployed? Y N Due to accident? Y N

*****Note: Circle, check- off or "fill- in" correct response. Leave no blanks!**

Accident Details:

Date of injury: ____/____/____. Time of day _____ AM / PM

Were you "on the job" at the time of the crash? Y N

Describe "in your own words" exactly how this crash happened: _____

Were you the : driver passenger: in front? / rear seat? motorcycle : driver? / passenger?
other: _____

Vehicle driven by: _____ Vehicle make, model & yr. _____

Was anyone else in the vehicle with you? Y N . If yes, who? _____

My estimated speed at time of impact was _____ mph. I was: stopped / slowing / accelerating

Other vehicle: make, model & yr.: _____

Time of day: daylight dawn dusk dark

Road condition: dry damp wet snow ice hailing other _____

My seat headrest: was adjustable not adjustable. It was: up / down / I don't recall

If it was adjustable: was it's original position changed by the crash? Y N

Was the "seat back" position altered by the crash? Y N . Was it broken by the crash? Y N

Lap/seat belt: used not used don't recall . Shoulder belt: used not used don't recall

Body position at time of impact? Good leaning forward other: _____

Head position? Looking forward? Turned: Right? or Left? looking up? looking down?

Hand position: one on the wheel two on the wheel don't remember

At time of crash, brakes applied? Y N

What direction was the crash impact in relation to where you were seated (circle one)?

Front / rear / left side / right side or left front / left rear / right front / right rear .

During the Crash

Did the air bag deploy? Y N . If yes, were you struck by it? Y N.

Were you taken by surprise, **unaware of the impending crash** Y N

Did any part of your **body strike any part of the vehicle**? Y N, If yes, describe: _____

Did you lose consciousness? Y N. If yes, how long? _____

Did **vehicle strike any objects** after the crash? Y N . Were you **wearing a hat or glasses**? Y N

Were they **still on after the crash**? Y N .

Estimated property **damage to your vehicle** \$ _____.

Estimated **damage to other vehicle**: none minimal moderate major

Were the **police on the scene**? Y N If so, did they **make a report**? Y N

Who, if anyone, received a ticket or citation from the police regarding this crash? _____

Please turn over to complete this form!

After the crash:

Immediately after the crash, did you go : home work hospital doctor_____.
Were you **taken by ambulance** anywhere? Y N If yes, where? _____.
Were you : admitted to the hospital? received *treatment in the emergency room* & released
What was done there? Exam x-rayed given medicine collar/ brace
If x-rayed, **what body parts** were imaged?: _____
If given **medication: name and dosage**-_____.
Any **follow up instructions** given? If yes, what were they?_____.

Have you seen any other doctor's before coming here? Y N . If yes, complete this section.

Dr. _____ specialty _____ treatment _____
Dr. _____ specialty _____ treatment _____
Dr. _____ specialty _____ treatment _____
Dr. _____ specialty _____ treatment _____

Notes: _____

Have you **missed work due to this injury**? Y N.. From ____/____/____ to ____/____/____.

Did you have any of the following symptoms following the crash:

Headache dizziness nausea confusion/disorientation neck pain

Numbness/tingling: if yes, where? _____

Pain in arms/legs: If yes, where? _____

Back pain? Where? _____

Which symptoms appeared **immediately**: _____

The **other symptoms** appeared app. _____ hours/days after the crash.

Past History of injury:

Have you **ever had the same or similar symptoms** before this crash? Y N

Explain: _____

Any **previous accidents / injuries**? Y N . **If yes, list them** and **circle** any that resulted in bodily injury: _____

Do you have any **disabling conditions or physical impairments** not due to this injury? Y N

If yes, Explain: _____

Insurance/Legal information

Was your *vehicle insurance* in effect and up to date at the time of the accident?_ Y N

Auto insurance co. name _____ Phone # () _____-

Address _____ Policy number _____

Do you have *medical payments coverage* on your auto policy? Y N. If yes, how much \$ _____

Do you have regular health insurance? Y N Insurance. Co name _____

Policy # _____ Phone # () _____-

Have you *hired an attorney* to represent you? If yes,... Name _____

Address _____ Phone # _____

By signing this form I attest that this information is complete and accurate to the best of my knowledge.

Signature _____ **Date** ____/____/____