Fusion Chiropractic, Inc.
Dr. Cynthia Seebacher
(o) 404-838-8985

3055 Johnson Ferry Road
Marietta, GA 30062
(f) 404-850-8645

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1) Your vehicle type:

car	van	large truck
SUV	pickup truck	bus

other_____

2) Your position in vehicle: driver front passenger left rear passenger right rear passenger
other_____

3) What was your vehicle doing at the time of the accident?

Stopped at intersection	making a right turn	proceeding along
stopped in traffic	making a left turn	slowing down
stopped at light	parking	accelerating

4) Time/Speed/Damage
   a. Time of accident_____am/pm
   b. Your vehicle's speed_____mph
   c. Their vehicle's speed_____mph

5) Details of accident
   a. Visibility at time of accident: poor fair good
   b. Who hit who/what?
      i. You hit other vehicle
      ii. Other vehicle hit you
      iii. You hit (object) _____

6) Road conditions
   a. Road condition at time of accident: icy wet sandy dark clean and dry
   b. Point of impact: head-on left front right front rear-end left rear right rear

7) Body position etc
   a. Did you see the accident coming: yes no
   b. Were you braced for the impact: yes no
   c. Did you have a seat belt on: yes no
   d. Did you have a shoulder harness on: yes no
   e. Does your vehicle have headrests: yes no
   f. What was the position of your headrest at the time of impact?

Even with top of head	Even with bottom of head	Middle of neck

   g. What was the direction of your head at the time of impact?

Facing straight forward	Turned to the right	Turned to the left

   h. Did the driver side air bags deploy: yes no
   i. Did the passenger side air bags deploy? Yes no
   j. Did the side airbags deploy: yes no

8) Additional accident information that has not been covered by the above questions:

_____

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9) During the accident:
   a. Did your body strike the inside of your vehicle? Yes No
      i. If yes, describe:_____
   b. Did you lose consciousness during the injury? Yes no
      i. If yes, how long:_____
   c. Did police show up at the scene? Yes no
   d. Was an accident report filled out? Yes no

10) After the accident, check symptoms right after and a few days following:

headache	fatigue	shortness of breath	depression
dizziness	ringing in ears	mid back pain	anxious
neck pain	tension	low back pain	toe numbness
nausea	irritability	cold hands	chest pain
neck stiffness	pain behind eyes	cold feet	sleeping problems
confusion	loss of smell	nervousness	
fainting	loss of taste	diarrhea	

other_____

11) Emergency room?
   a. Where did you go after the accident?
      Home Work Hospital ER Private doctor
   b. How did you get there?
      Drove self Somebody else drove Ambulance Police
   c. Were X-rays done? Yes no
      i. What body parts X-rayed:_____
      ii. What X-rays revealed:_____
      iii. Do you have copies of your X-rays? Yes no
   d. Was lab work done? Yes no what kind?_____
   e. Treatments: cervical collar ice other_____
   f. Medications:_____
   g. Follow up instructions:_____

12) Treatment History: fill in any other doctor(s) seen prior to your first visit to this office
   a. Dr._____ first visit date_____
      i. Specialty_____
      ii. X-rays done yes no
      iii. How many treatments received? _____ Currently treating? Yes no
      iv. Did treatments benefit you? Yes no
      v. Last visit date _____
   b. Dr._____ first visit date_____
      i. Specialty_____
      ii. X-rays done yes no
      iii. How many treatments received? _____ Currently treating? Yes no
      iv. Did treatments benefit you? Yes no
      v. Last visit date _____