Fusion-Chiro.com
Dr. Cynthia Seebacher, D.C.

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(404)838-8985

Automobile Accident Description

Name:______________________________________ Date of Accident___________

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	other____________
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 ______________________________________