

SLATER CHIROPRACTIC
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Automobile Accident History Form

Name: _____ SS# _____ Date _____

Date of Accident: _____ Time of Acc _____ AM PM

City of Accident: _____ St of Accident _____

Road conditions at the tie of accident: Wet Dry Icy Other

Did the police come to the accident scene?

Were you taken to a hospital? Yes No What is the name of hospital _____ City _____

How did you get the the hospital? _____

What parts of your body were x-rayed at the hospital? _____

The following questions pertain to you, the patient, and the vehicle you were in:

1. Where were you seated in the vehicle? _____
2. Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?

3. Did you lose consciousness upon impact? _____
4. If you did lose consciousness, estimate for how long. _____
5. How far is the top of the headrest or seat back from the top of your head? _____ inches *above / below*
6. Were you wearing a seat belt? _____ If "yes" was it a lap or shoulder _____
7. List the year, make, and model of the vehicle you were in:
Year _____ Make _____ Mode _____
8. Was your car stopped at the time of impact? _____ if "yes" then was the driver's foot also on the brake? _____ If "no" then estimate the speed of the vehicle you were in _____ m.p.h.
9. if the vehicle was moving at the time of impact, was it slowing down? _____ or was it gaining Speed? _____ or was it traveling at a steady rate of speed _____ at the time of impact.
10. please describe, to the best of your knowledge, what happened during this accident:

11. What bleeding cuts did you get during this accident? _____

12. What bruises did you get during this accident? _____

13. On what part of the auto did the following body parts hit:

- A. Head _____
- B. Chest _____
- C. Rt or Left shoulder _____
- D. Rt or Lt arm _____
- E. Rt or Lt hip _____
- F. Rt or Lt leg _____
- G. Rt or Lt knee _____
- H. Other _____

14. What is the cost damage to the vehicle you were in? _____

15. What of the following car parts broke during the accident?

- A. Windshield
- B. Front seat back
- C. Rt or Lt side window
- D. Steering
- E. Other _____

16. Was the trunk of your body pointed straight forward at the time of collision? _____
If "no" which direction was it turned, and by how much. _____

17. Was your head pointed straight forward? _____ If "no" what direction was it turned, and by how
much. _____

The following questions pertain to the other vehicle involved in the accident:

1. What is the year, make and model of the other vehicle? _____

2. Was the other vehicle moving at the time of the collision? _____ If "yes" what was its
approximate speed? _____ m.p.h

3. If the other vehicle was moving at the time of collision, was it slowing down? _____:
gaining speed _____: or traveling at a steady speed _____

If you have any previous auto accidents, please list the year each was in:

