LOWREY
CHIROPRACTIC
INTEGRATED WELLNESS

Auto Accident Description

In order to provide you the best possible chiropractic wellness care, please complete this form (print clearly).
All information is strictly CONFIDENTIAL.

Accident Information *(please print clearly)*

Name: _____ Date of Birth: _____
First M.I. Last

Date of Injury: _____ Time of Injury : _____ □ AM □ PM

City and street where crash occurred: _____

Insurance Information: *(please print clearly)*

Have you reported this injury to your auto insurance company? □ Yes □ No

Did the police come to the accident scene and make a report? □ Yes □ No

Estimated Damage? $ _____ Do you have automobile medical insurance coverage? □ Yes □ No

If Yes: Auto Insurance Company Name: _____

Auto Insurance Address: _____ Phone: _____

What is your automobile insurance medical coverage limit? $_____ Claim #: _____

Insurance claim adjuster's name? _____

Attorney Information: *(please print clearly)*

Is an attorney representing you? □ Yes □ No

If yes: Attorney's Name: _____

Address_____ Phone: _____

Description of Accident *(please print clearly)*

DESCRIBE HOW THE CRASH HAPPENED:_____

_____

_____

COLLISION DESCRIPTION: *(Check all that apply to you)*
Were you involved in the following type of accident:

□ Single-car crash	□ Two-vehicle crash	□ Three or more vehicles
□ Rear-end crash	□ Side crash	□ Rollover
□ Head-on crash	□ Hit guardrail/trec	□ Ran off road

You Were The: □ Driver □ Front Passenger □ Rear passenger

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DESCRIBE THE VEHICLE YOU WERE IN:

Model Year and Make: _____

□ Small car □ Mid-sized car □ Full-sized car
□ Pick-up truck/sports utility □ Large truck □ Large bus or semi-truck

DESCRIBE THE OTHER VEHICLE:

Model Year and Make: _____

□ Small car □ Mid-sized car □ Full-sized car
□ Pick-up truck/sports utility □ Large truck □ Large bus or semi-truck

ESTIMATED CRASH SPEEDS:

Estimate how fast your vehicle was moving at time of crash _____ mph □ Unknown
Estimate how fast other vehicle was moving at time of crash _____ mph □ Unknown

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

□ Slowing down □ Gaining speed
□ Stopped □ Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

□ Slowing down □ Gaining speed
□ Stopped □ Moving at steady speed

DURING AND AFTER THE CRASH, YOUR VEHICLE:

□ Kept going straight, not hitting anything □ Spun around, not hitting anything
□ Kept Going straight, hitting car in front □ Spun around, hitting another car
□ Was hit by another vehicle □ Spun around, hitting object other than car

CRASH DESCRIPTIONS: (*Check only and all areas that apply to you)*

□ You were unaware of the impending collision
□ You were aware of the impending crash and relaxed before the collision
□ You were aware of the impending crash and braced yourself
□ Your body, torso, and head were facing straight ahead
□ You had your head and/or torso turned at the time of collision to the □ Left □ Right

YES	NO	***(Please Answer Yes or No to the Following Questions)***
□	□	Were you intoxicated (alcohol) at the time of crash?
□	□	Were you wearing a seatbelt?
□	□	If yes, does your seatbelt have a shoulder harness?
□	□	Were you holding onto the steering wheel at the time of impact?
□	□	If you were involved in a rear-end crash, did your car separate away from the striking vehicle after the crash? If yes, you are indicating that after the crash your car was pushed away from the striking vehicle and your vehicle did not stay attached.

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INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:
(Please draw lines and match the left side to the right side)

Head	Windshield
Face	Side window
Shoulder	Side door
Arm/hand	Dashboard
Front chest wall	Knee Bolster/glove compartment
Side chest wall	Seatbelt
Hip/abdomen	Frame of car near windows
Knee	Roof of vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

□ Windshield	□ Seat frame	□ Knee bolster
□ Steering wheel	□ Side-rear window	□ Other
□ Dash	□ Mirror	□ Other

REAR-END COLLISIONS ONLY *(Answer this section only if you were hit from the rear)*
Does your vehicle have
- □ Movable/adjustable headrest
- □ Fixed, non-movable headrest

Please indicate how your headrest was positioned at the time of crash.*
- □ At the top of the back of your head
- □ Midway height of the back of your head
- □ Lower height of the back of your head
- □ Located at the level of your neck
- □ Located at the level of your shoulder blades (upper back) below neck

* Estimate the distance between the back of your head and the front of the headrest_____ inches

ALL TYPES OF COLLISIONS
(Answer this section regardless of the type of crash, indicating those relevant to your case)

YES	NO	
□	□	Did any of the front or side structures of your car dent inward during the crash?
□	□	Did the side door touch our body during the crash?
□	□	Did your body slide under the seatbelt?
□	□	Was the door(s) of your vehicle damaged to point where you could not open the door?
□	□	Have you noticed any bruising on your body since the accident?

EMERGENCY ROOM

	Yes	No
Did you go to the emergency room afterward?	□	□
What is the name of the emergency room? _____		
When did you go (date and time)? _____		
Did you go to emergency room in an ambulance?	□	□
Did you or another person drive you to emergency room?	□	□
Were you hospitalized overnight?	□	□

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	Yes	No
Did emergency room doctor take X-Rays? If yes, check what region was taken.	□	□
□ Skull □ Neck □ Low back □ Arm or leg		
Did the emergency room doctor give you pain medications?	□	□
Did the emergency room doctor give you muscle relaxants?	□	□
Did you have any cuts or lacerations?	□	□
Did you require any stitching for cuts?	□	□
Were you given a neck collar or back brace to wear?	□	□

WHEN DID YOU FIRST NOTICE ANY PAIN AFTER INJURY?
□ Immediately □ Hours after injury □ Days after injury

IF YOU DID NOT SEE A DOCTOR FOR THE FIRST TIME WITHIN THE FIRST WEEK, INDICATE WHY *(Check all that apply only if you had delay in seeing doctor)*
□ No pain was noticed □ No appointment schedule available
□ No transportation □ Work/home schedule conflicts

IF YOU DID NOT SEE A DOCTOR FOR THE FIRST TIME WITHIN THE FIRST MONTH AFTER INJURY, INDICATE WHY? *(Check all that apply)*
□ No pain was noticed □ No appointment schedule available
□ No transportation □ Work/home schedule conflicts
□ I thought pain would go away □ I had no insurance or money
□ I self-treated with over-the-counter drugs □ Other

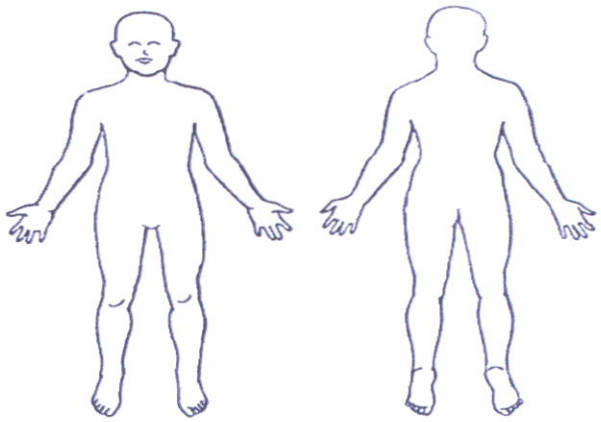
HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?
□ YES □ NO If yes, you were off work: □ partially or completely

Please list all dates off work: From _____ to: _____

PAIN DRAWING:

Please read carefully: Mark the areas on your body where you feel **pain**. Include all affected areas. Use the appropriate symbols below.

Ache ››› Numbness ▪▪▪▪ Pin and Needles □□□□
Burning xxxx Stabbing //// Throbbing _ _ _ _



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SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail. Look at the symptoms listed below and make it a single check mark or several check marks I the appropriate columns for the specific symptom which applies to you. Leave the row blank if the symptom listed does not apply to you.

SYMPTOM LIST	FELT RIGHT AFTER INJURY	FELT 24-48 HOURS LATER	HAVE SYMPTOMS NOW	HAD SIMILAR SYMPTOMS 1-3 MONTHS BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain				
Neck pain/soreness				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain				
Rib cage pain				
Low back pain/soreness				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain primarily in front of thighs				
Knee pain				
Ankle/foot pain				
Other				