Denver Headache & Spine Center P.C.
Dr. Randy L. James DC BCAO
Automobile Accident History Form

Name: _____ Claim # _____ Date: _____

Date of accident:_____ Time of accident:_____

City of accident:_____ Street of accident: _____

Road conditions at the time of the accident: _____

Did the police come to the accident scene? Y/N

Were you taken to the hospital? Y/N If yes, hospitals name: _____

City of hospital:_____ How did you get to 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 impact catch you by surprise? _____
3. Did you lose consciousness (black out) upon impact? _____
4. If you did lose consciousness, estimate for how long. _____
5. How far is the top of the headrest or seatback from the top of your head? _____
6. Were you wearing a seatbelt? Y/N ; If yes, then was it a lap seatbelt or a shoulder-lap seatbelt?_____
7. List the year, make, and model of the vehicle you were in at the time of the accident:
   Year:_____ Make:_____ Model: _____
8. Was your car stopped at the time of impact? Y/N ; If yes, then was the driver's foot also on the brake? Y/N ; If no, then estimate the speed of the vehicle you in:_____ MPH.

9. If the vehicle was moving at the time of impact, was it slowing down, gaining speed, or traveling at a steady rate of speed at the time of impact?

_____

10. 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. Was the trunk of your body pointed straight forward at the time of collision? Y/N ; If no, which direction was it turned and by how much?_____

_____

14. Was your head pointed straightforward? Y/N
If no, what direction was it turned and by how much? _____

_____

15. On what part of the auto did the following body parts hit:
    A. Head:
    B. Chest
    C. Rt. or Lt. Shoulder
    D. Rt. or Lt. Arm
    E. Rt. or Lt. Hip
    F. Rt. or Lt. Leg
    G. Rt. or Lt. Knee
    H. Other

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

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

2. Was the other vehicle moving at the time of the collision? Y/N ; If yes, what was its approximate speed? _____ MPH.

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