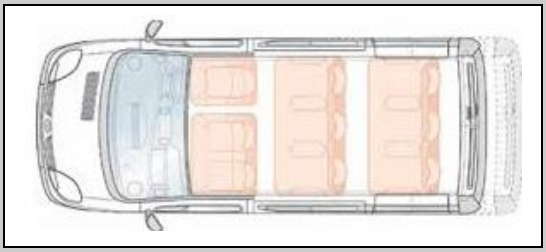
CHIROPRACTIC
HEALTH & SPINE

2112 North Hwy 81 * Anderson, SC 29621 * (864) 224-9700

Motor Vehicle Crash

What was the date of the accident?	What time did the accident occur? am or pm
How many vehicles were involved in the accident?	What was the estimated damage to the vehicle you were in?
What state did the accident occur in?	What city did the accident occur in?
What type of impact was the auto accident?	Did your vehicle hit anything after the accident? If yes, please describe.
Where were you sitting in the vehicle during the accident? ☐ Driver ☐ Front Passenger ☐ 2nd Row Behind Driver ☐ 2nd Row Passenger Side ☐ 3rd Row Behind Driver ☐ 3rd Row Passenger Side	Please mark where you were sitting during the accident. 
Did you know the accident was coming?	What type of vehicle were you in?
What type of vehicle impacted yours?	At the time of the impact, how fast was your vehicle moving?

During and after the crash what happened to your vehicle? Check all that apply.

☐ Kept going straight
☐ Kept going straight hitting a car in front
☐ Was hit by another vehicle
☐ Spun around
☐ Spun around and hit a stationary object
☐ Hit a stationary object

Damages

Did you lose consciousness during the accident? ☐ Yes ☐ No	
How was your head positioned during the accident?	How was your torso positioned during the accident?
How were your hands positioned during the accident?	Did your head hit anything during the accident? ☐ No ☐ Yes. Describe:
Did your face hit anything during the accident? ☐ No ☐ Yes. Describe:	Did your shoulders hit anything during the accident? ☐ No ☐ Yes. Describe:
Did your neck hit anything during the accident? ☐ No ☐ Yes. Describe:	Did your chest hit anything during the accident? ☐ No ☐ Yes. Describe:
Did your hips hit anything during the accident? ☐ No ☐ Yes. Describe:	Did your knees hit anything during the accident? ☐ No ☐ Yes. Describe:
Did your feet hit anything during the accident? ☐ No ☐ Yes. Describe:	What kind of headrest was in your vehicle? ☐ Moveable Fixed Headrest ☐ Non-moveable Fixed Headrest ☐ No Headrest
Where was the headrest positioned on your head?	Did you have your seatbelt on during the accident? ☐ Yes ☐ No
Did you slide out of your seatbelt during the accident? ☐ Yes ☐ No	

What was damaged in your vehicle? Check all that apply.

☐ Windshield	☐ Rear Bumper	☐ Mirror
☐ Steering Wheel	☐ Front Bumper	☐ Knee Bolster
☐ Dashboard	☐ Trunk	☐ Back Right Door
☐ Seat Frame	☐ Front Left Door	☐ Completely Totaled
☐ Side Window	☐ Front Right Door	
☐ Rear Window	☐ Back Left Door	

Choose the items that dented inward. ☐ floorboards ☐ side door ☐ dashboard

Choose the doors that would not open as a result of the accident.

☐ front left	☐ front right
☐ rear left	☐ rear right

Did you go to the hospital? ☐ No – You are finished with this form.
☐ Yes – Answer the rest of this form.

How did you get to the hospital?	What was the name of the hospital?
Were you hospitalized overnight? ☐ Yes ☐ No	Check what you were prescribed at the hospital. ☐ Pain Medication ☐ Muscle Relaxers ☐ Neck Brace
Did you receive any stitches for any cuts at the hospital? ☐ No ☐ Yes	Were x-rays taken at the hospital? ☐ No ☐ Yes. Which Area?