NAME _____ DATE _____

MOTOR VEHICLE ACCIDENT CASE RECORD

1. DATE of INJURY _____ TIME of INJURY _____

2.WHERE did ACCIDENT HAPPEN? _____

_____

3. BRIEF STATEMENT as to how ACCIDENT OCCURRED _____

_____

_____

4. Were There ANY CHARGES ARISING from the ACCIDENT? NO ____ YES ____ *if yes,*

who was charged with causing the accident? _____

5. TYPES of VEHICLE(s) INVOLVED in the ACCIDENT: _____

_____

6. Would you describe the accident as a:

a) single vehicle b) multi vehicle c) chain reaction d) roll over e) car/pedestrian

7. What was the point of impact on your vehicle: *(Circle as many as apply)* a) head-on b) rear-ended

c) rt. front d) lt. front e) rt. side f) lt. side g) rt. rear h) lt. rear i) totalled, vehicle written off

8. Position of Patient: Driver ___ Mid ___ Co-driver ___ Passenger in Rear Seat: Rt ___ Ct ___ Lt___

9. Were YOU wearing a SEATBELT? YES ____ NO____ Shoulder Restraint? YES ____ NO ____

10. Was the HEADREST high enough to restrain the backward motion of your head? YES ____ NO ____

11. What was the total number of occupants in your vehicle? _____

12. Was anyone else injured? NO ____ YES ____ if yes, state extent of their injuries:

a) minor ____ b) moderate ____ c) severe ____ Note:_____

13. What occurred as the result of the impact? *(circle as many letters as apply)*

A) Tensed body for impact B) Neck whipped forward and back C) Body wrenched sideways

D) Thrown from seat E) Vehicle rolled over F) Vehicle propelled into another vehicle

G) Vehicle spun H) Thrown from Vehicle I) Vehicle was crushed, patient was trapped inside

14. What would you estimate the speed of the vehicle that struck you? _____Km/hr.

15. Was your vehicle: Parked ____ Stationary *(foot on brake)* ____ Slowly rolling ____

Making a corner ____ driving highway speeds ____ driving city speeds ____

16. Did you strike anything on impact? a) NO b) windshield c) steering wheel d) dash

e) side glass f) roof g) rear window h) objects lose in the vehicle

17. SYMPTOMS (*how you felt <u>immediately</u> following the accident) (Circle as many as apply)*

A. (a) Normal (b) confused (c) dazed (d) numbed (e) shock (f) disassociated (g) stupor

EXPLAIN_____

B. (a) Normal consciousness (b) unconscious (c) loss of awareness (d) disoriented

(e) cold sweat (f) faint (g) numbness (h) tingling (i) other _____

C. If other than normal: (i) which symptom(s) _____

(ii) how long did symptom(s) last_____

D. Did you experience any loss of motor control? NO ____ YES ____ if yes, in what area(s)?

_____

E. Did you experience any: NAUSEA: NO ____ YES ____ VOMITING: NO ____ YES ____

F. Did you experience any: (i) Visual disturbance: NO ____ YES ____

(ii) Ringing in the ears: NO ____ YES ____

(iii) Immediate pain: NO ____ YES ____ if yes, where

_____

G. Did you experience any: (i) cuts NO ____ YES ____ where? _____

(ii) scrapes NO ____ YES ____ where? _____

(iii) cuts requiring stitches NO ____ YES ____ where?

_____

(iv) broken bones NO ____ YES ____ if yes, where?

_____

_____

NAME _____ DATE _____

18. CARE OR TREATMENT TO DATE

A) On the day of the accident were you:

(i) taken to the hospital by ambulance NO ____ YES ____ if yes, which hospital?

_____

(iii) at the hospital, what was the course of examination?

physical exam ____ x-rays _____ other _____

(iv) Do you know who examined you? NO ____ YES ____ if yes, please state?

_____

(v) Were you: Admitted to hospital NO ___ YES ___ Released after examination YES ___ NO ___

B) On the day of the accident were you taken to: *(other than ambulance)*

Emergency _____ Medicentre _____ Family doctor _____ This office _____

another chiropractor _____ your home _____ Phoned for advice _____ Resumed activities ____

19. Have you been examined by ANYONE since the accident? NO ____ YES ____ *if yes, complete the following.*

A.

a) Name _____ Type of Practice _____

b) Diagnosis or Explanation Provided _____

c) Treatment provided _____

d) Dates of appointments _____

e) Outcome: i) improvement ii) no change iii) worse iv) complications

B.

a) Name _____ Type of Practice _____

b) Diagnosis or Explanation Provided _____

c) Treatment provided _____

d) Dates of appointments _____

e) Outcome: i) improvement ii) no change iii) worse iv) complications

C.

a) Name _____ Type of Practice _____

b) Diagnosis or Explanation Provided _____

c) Treatment provided _____

d) Dates of appointments _____

e) Outcome: i) improvement ii) no change iii) worse iv) complications

D.

a) Name _____ Type of Practice _____

b) Diagnosis or Explanation Provided _____

c) Treatment provided _____

d) Dates of appointments _____

e) Outcome: i) improvement ii) no change iii) worse iv) complications

20. Do you have a preexisting condition that since the accident became worse? NO ____ Yes ____

if yes, please state. _____

21. Did you have any previous condition that may have made you more vulnerable to this accident?

NO ____ YES ____ if yes, please state _____

22. To date do you feel your injuries arising from this accident are:

(a) improving **(b)** good days, bad days **(c)** same **(d)** worse in some areas **(e)** overall worse

23. Do to the accident did you lose any Personal Belongings: ie. glasses, etc. NO ____ YES ____ if yes, please state _____

24. Have you consulted a lawyer? NO ____ YES ____

25. Have you been contacted by an insurance adjustor? NO ____ YES ____ if yes, which company?

Name of adjustor _____Company _____

26. Have you contacted your own insurance agent? NO ____ YES ____

Name of Your Insurance Company _____

27. Have you had any time loss from work due to this accident? NO ____ YES ____ if yes, give dates of time loss: from _____ to _____