Do they have an attorney? ☐ Yes ☐ No

Was it your car? ☐ Yes ☐ No If not, whose? _____

Were you reclined? ☐ Yes ☐ No Position of headrest _____

What time of day was the accident? ☐ Daylight ☐ Night ☐ Dusk ☐ Dawn

What were the weather conditions? _____

Were you tired? ☐ Yes ☐ No Were you awake? ☐ Yes ☐ No

How long had you been in the car? _____

Where were you prior to the accident? _____

What were the traffic conditions? _____

What was the posted speed limit? _____ How fast were you going? _____

Type of road: ☐ 2 lane ☐ 4 lane ☐ gravel ☐ tar

Did it happen at a: ☐ stop sign ☐ traffic light ☐ highway

Where was your car hit? ☐ front ☐ back ☐ left side ☐ right side

What damage was done to your car?

Inside _____

Outside _____

Other _____

If you struck another car, where did you strike it? ☐ front ☐ back ☐ left side ☐ right side

What was the damage to the other car?

Inside _____

Outside _____

Did your vehicle strike anything? ☐ Yes ☐ No

If yes, what? ☐ another car ☐ tree ☐ sign ☐ bridge ☐ hedge ☐ embankment ☐ other _____

Did your vehicle go off the road? ☐ Yes ☐ No If yes: ☐ into a ditch ☐ into an embankment

Were you completely conscious after the accident? ☐ Yes ☐ No

Do you remember the impact? ☐ Yes ☐ No

Does it bother you to ride in a car now? ☐ Yes ☐ No

If so, as a: ☐ driver ☐ passenger

State any strange events that happened during or immediately after the accident:

_____

_____

_____

Patient Signature: _____ Date: _____

Indigo Chiropractic
Your path to wellness

Roger P. Smith, D.C.
Santa Fe Medical Plaza
9755 N. 90th St., Suite B-150
Scottsdale, AZ 85258

AUTOMOBILE ACCIDENT HISTORY

Name _____ Age _____ Date of Birth _____ ☐M ☐F

Address _____ City _____ State _____ Zip _____ Phone Number _____

Social Security # _____ Work Phone _____ Occupation _____ Employer _____

Height: _____ Weight: _____ Health Insurance? ☐Yes ☐No

Name of Insurance Company _____ ID# _____ Name of Insured _____

Name of Attorney _____ Phone Number _____ Address _____

Date of Accident _____ Time of Accident _____ am/pm Accident Location _____

☐Yes ☐No Was police report made? _____ Which city? _____ Who was ticketed? _____

☐Yes ☐No Were you hospitalized? _____ Which hospital? _____ How many days? _____ Did you see any other Doctor? Who? _____

ACCIDENT INFORMATION

Did you hit any part of your body during the collision, for example; head on dash, chest on steering wheel, etc? ☐Yes ☐No

If yes, which part and how? _____

What is your chief complaint? _____

State how the accident happened in your own words: _____

_____

_____

Have you ever been injured in a similar manner? ☐Yes ☐No

If yes, how and when? _____

_____

What type of vehicle were you in? Year _____ Make/Model _____

Were you driving? ☐Yes ☐No If no, who was driving? _____

Other people in the car? ☐Yes ☐No Who? _____

Do they need medical treatment? ☐Yes ☐No