Saleeby Chiropractic Centre, P.A.

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AUTO ACCIDENT MECHANISM OF INJURY FORM

Patient's Name: _____ DOB:_____ Z Code:_____

Date of Collision: _____ Hour of accident: _____ AM/PM

Location of Accident: _____

Please describe how the collision happened: _____
_____
_____
_____

●What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

●If "Driver", were your hands on the steering wheel? **Both / Left / Right**

●Did the airbags deploy? **Yes / No**

●Did you strike another vehicle? **Yes / No**

●Angle of Impact: **Front / Back / Left / Right / Other**: _____

●If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other** : _____

●In relation to the back of your head, was your headrest set: **Low / Middle / High**

●Were you surprised by the impact? **Yes / No**

If "NO", how did you brace? **With Hands / With Feet**

●Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

●Were you leaning forward at the time of impact? **Yes / No**

●What type and year of vehicle were you in? _____

●What was the approximate speed of your vehicle when the accident occurred? _____mph

●What type and year of vehicle struck yours? _____

●What was the approximate speed of the other vehicle when the accident occurred? _____mph

●Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

●Did you feel pain immediately after the accident? **Yes / No**

●Were you rendered unconscious as a result of the accident? **Yes / No**

●Did you strike anything in the vehicle at the time of impact? **Yes / No**

If "Yes", specify what part of the body struck what: (i.e. head to windshield) _____

●Did your seat bend or break? **Yes / No**

●Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other** : _____

Police and Ambulance:

●Was the accident reports to the police? **Yes / No**

●Were traffic citations issued? **Yes / No** If "YES", to whom? _____

●Did you go to the hospital? **Yes / No** If "YES", when? _____

●If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

●Were you admitted? **Yes / No** If "YES", how long? _____

●Name of Hospital? _____ Attended by Dr. _____

●What treatment was given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to call a Private Physician / Referred to This Office / Other:** _____

●What other doctor have you seen as a result of this injury? _____

●Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**

●Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**

●Symptoms other than above: _____

_____

Patient Signature **Date**

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