ADIRONDACK CHIROPRACTIC **James Kolwaite D.C.** **587 Main St NY Mills NY**

AUTOMOBILE ACCIDENT HISTORY

315-768-7578

Name: _____Age: _____ Date of Birth: _____ Date_____

Address: _____Phone_____

City: _____ State: _____ Zip: _____

SS#: _____ Driver's License #: _____

Insurance Company: _____ Name of Agent: _____

Address of Insurance Company: _____

Have you retained an attorney? ❑ Yes ❑ No Name and Address of Attorney: _____

_____

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision, i.e.: head on dash, chest on steering wheel? ❑ Yes ❑ No

If yes, which part and how? _____

_____

Where were you taken after the accident? _____

Were you hospitalized? ❑ Yes ❑ No If yes, for how long? _____

Did you receive care from any other health care specialist? ❑ Yes ❑ No If yes, what is the specialist's name?

_____

What type of care were you given and for how long? _____

Where did you feel the pain? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? ❑ Yes ❑ No If yes, how and when? _____

_____

ACCIDENT HISTORY:

Date of Accident: _____Time of Accident: _____ ❑ A.M. ❑ P.M.

State how accident happened in you own words: _____

_____

_____

What type of vehicle were you in? Make: _____ Year: _____

Were you driving? ❑ Yes ❑ No Was it your car? ❑ Yes ❑ No If not, whose? _____

❑ Passenger? ❑ Front ❑ Back ❑ Right Side ❑ Left Side Were you rotated in seat? ❑ Yes ❑ No

Were you reclined? ❑ Yes ❑ No Other: _____

Other people in car? ❑ Yes ❑ No Names and Addresses: _____

_____

Were they injured? ❑ Yes ❑ No If yes, explain: _____

Seat belts on? ❑ Yes ❑ No Shoulder harness on? ❑ Yes ❑ No Position of Headrest: _____

Was it? ❑ 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? _____ Did it happen at a/an: ❑ stop sign ❑ traffic light ❑ intersection ❑ highway

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, did you strike it: ❑ Front ❑ Back ❑ Side What was the damage to the other car?

Inside: _____

Outside: _____

In what condition was the vehicle prior to the accident? _____

What type of vehicle was involved in the accident?

❑ Car ❑ Truck ❑ Motorcycle ❑ Other: _____ Size and Type: _____

Was accident report made? ❑ Yes ❑ No Police of: City: _____ County: _____ State: ___

Who was ticketed? _____ For what? _____

Did your vehicle strike anything? ❑ Yes ❑ No If yes, ❑ Another car ❑ Sign ❑ Tree ❑ Bridge ❑ Hedge

❑ An Embankment ❑ Other: _____ Size and Type: _____

Were you completely conscious after the impact? ❑ Yes ❑ No

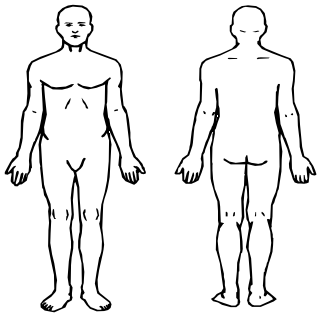
Do you remember the impact? ❑ Yes ❑ No Did your vehicle go off the road? ❑ Yes ❑ No

If so, ❑ Into a ditch? ❑ An Embankment? Does it bother you to ride in a car now? ❑ Yes ❑ No

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

_____

Have you had any time loss from work? ❑ Yes ❑ No If yes, from _____ to _____



MARK PAIN AREA

+ + + Burning

0 0 0 Stabbing

- - - Sharp

| | | Constant

Patient Signature _____ Date _____ Staff Signature _____