

AUTOMOBILE ACCIDENT

SPORTSDOCS FAMILY CHIROPRACTIC

L. Jon Porman, DC, CCSP, RTP

Name: _____ Chart #: _____ Today's Date: _____ Accident Date: _____

****Please Check All That Apply****

DESCRIBE THE VEHICLE

| | | | | | |
|--------------------------------|--|---|---|----------------------------------|------------------------------|
| <u>Patient's vehicle type:</u> | <input type="checkbox"/> Sports car | <input type="checkbox"/> Sedan | <input type="checkbox"/> Station wagon | <input type="checkbox"/> truck | <input type="checkbox"/> Bus |
| | <input type="checkbox"/> Coupe | <input type="checkbox"/> Sports-utility vehicle | <input type="checkbox"/> Pick-up truck | <input type="checkbox"/> Van | |
| <u>Vehicle size:</u> | <input type="checkbox"/> Full Size | <input type="checkbox"/> Sub Compact | <input type="checkbox"/> Sub-compact | <input type="checkbox"/> Compact | |
| | <input type="checkbox"/> Light | <input type="checkbox"/> Semi | <input type="checkbox"/> Semi | | |
| <u>Position in vehicle:</u> | <input type="checkbox"/> Front mid passenger | <input type="checkbox"/> Rear mid passenger | <input type="checkbox"/> Rear right passenger | | |
| | <input type="checkbox"/> Front right passenger | <input type="checkbox"/> Rear left passenger | <input type="checkbox"/> Driver | | |

DESCRIBE THE ACCIDENT

| | | | |
|-----------------------------------|---|--|--|
| <u>Action of patient vehicle:</u> | <input type="checkbox"/> Stopped for pedestrian | <input type="checkbox"/> Traveling faster than speed limit | <input type="checkbox"/> Stopped at intersection |
| | <input type="checkbox"/> Stopped in traffic | <input type="checkbox"/> Traveling slower than speed limit | <input type="checkbox"/> Turning left |
| | <input type="checkbox"/> Traveling speed limit | <input type="checkbox"/> Crossing intersection | <input type="checkbox"/> Turning right |
| <u>Patient's vehicle was hit:</u> | <input type="checkbox"/> On the left front | <input type="checkbox"/> By a light truck | <input type="checkbox"/> Was rear-ended |
| | <input type="checkbox"/> On the right front | <input type="checkbox"/> On the right rear | <input type="checkbox"/> Sideswiped on the right |
| | | <input type="checkbox"/> Sideswiped on the left | <input type="checkbox"/> Head-on |
| <u>Patient's vehicle hit:</u> | <input type="checkbox"/> Left rear of other vehicle | <input type="checkbox"/> Rear-ended other vehicle | <input type="checkbox"/> Left front of other vehicle |
| | <input type="checkbox"/> Right rear of other vehicle | <input type="checkbox"/> Side swiped other vehicle on the left | <input type="checkbox"/> Other vehicle head-on |
| | <input type="checkbox"/> Right front of other vehicle | <input type="checkbox"/> Sideswiped other vehicle on the right | |
| <u>Damage:</u> | <input type="checkbox"/> Complete | <input type="checkbox"/> Extensive | <input type="checkbox"/> Moderate |
| | | | <input type="checkbox"/> Minimal |
| <u>Patient's vehicle was hit:</u> | <input type="checkbox"/> By a subcompact car | <input type="checkbox"/> By a full-sized car | <input type="checkbox"/> By a pick-up truck |
| | <input type="checkbox"/> By a compact car | <input type="checkbox"/> By a mini-van | <input type="checkbox"/> By a light truck |
| | <input type="checkbox"/> By a mid-sized car | <input type="checkbox"/> By a full-sized van | <input type="checkbox"/> By a sport-utility vehicle |
| <u>Patient's vehicle hit:</u> | <input type="checkbox"/> A subcompact car | <input type="checkbox"/> A full-sized car | <input type="checkbox"/> A pick-up truck |
| | <input type="checkbox"/> A compact car | <input type="checkbox"/> A mini-van | <input type="checkbox"/> A light truck |
| | <input type="checkbox"/> A mid-sized car | <input type="checkbox"/> A full-sized van | <input type="checkbox"/> A sport-utility vehicle |
| <u>Damage to other vehicle:</u> | <input type="checkbox"/> Complete | <input type="checkbox"/> Extensive | <input type="checkbox"/> Moderate |
| | | | <input type="checkbox"/> Minimal |
| <u>Weather conditions:</u> | <input type="checkbox"/> Cloudy | <input type="checkbox"/> Foggy | <input type="checkbox"/> Snowing |
| | <input type="checkbox"/> Drizzling | <input type="checkbox"/> Rainy | <input type="checkbox"/> Storming |
| | | | <input type="checkbox"/> Sunny |
| | | | <input type="checkbox"/> Clear |
| <u>Road conditions:</u> | <input type="checkbox"/> Dry | <input type="checkbox"/> Iced over | <input type="checkbox"/> Wet |
| | <input type="checkbox"/> Dry with icy patches | <input type="checkbox"/> Snowed over | <input type="checkbox"/> Damp |
| <u>Time of day:</u> | <input type="checkbox"/> Dawn | <input type="checkbox"/> Daylight | <input type="checkbox"/> Dusk |
| | | | <input type="checkbox"/> Night |
| <u>Visibility:</u> | <input type="checkbox"/> Fair | <input type="checkbox"/> Good | <input type="checkbox"/> Poor |

DESCRIBE MOMENT OF IMPACT

| | | | |
|---|--|--|--|
| <u>Body position at impact:</u> | <input type="checkbox"/> Slouched in seat | <input type="checkbox"/> Turned left | <input type="checkbox"/> Leaning forward |
| | <input type="checkbox"/> Straight | <input type="checkbox"/> Turned right | |
| <u>Body position at impact:</u> | <input type="checkbox"/> Backward then forward | <input type="checkbox"/> To the left | <input type="checkbox"/> About the vehicle |
| | <input type="checkbox"/> Forward then back | <input type="checkbox"/> To the right | <input type="checkbox"/> Under the vehicle |
| | | <input type="checkbox"/> Outside the vehicle | |
| <u>Head position at impact:</u> | <input type="checkbox"/> Straight | <input type="checkbox"/> Tilted Forward | <input type="checkbox"/> Turned Left |
| | | | <input type="checkbox"/> Turned right |
| <u>Direction head was thrown:</u> | <input type="checkbox"/> Back then forward | <input type="checkbox"/> Forward then back | <input type="checkbox"/> Side to side |
| <u>Type of passive restraint:</u> | <input type="checkbox"/> Airbag | <input type="checkbox"/> Lap belt | <input type="checkbox"/> Shoulder belt |
| | | | <input type="checkbox"/> Shoulder-lap belt |
| <u>Did airbag deploy?:</u> | <input type="checkbox"/> Deployed | <input type="checkbox"/> Did not deploy | <input type="checkbox"/> Side |
| | | | <input type="checkbox"/> Front |
| <u>Position of head rest:</u> | <input type="checkbox"/> High position | <input type="checkbox"/> Low position | <input type="checkbox"/> Middle position |
| | | | <input type="checkbox"/> not installed |
| <u>Did you brace for impact?:</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <u>Did you lose consciousness?:</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <u>Did your body strike anything in the vehicle?:</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

DESCRIBE WHAT HAPPENED AFTER IMPACT

| | | |
|---------------------------------------|---------------------------------------|---|
| <u>Did the police show up?:</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <u>Was an accident report filed?:</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <u>Where did you go after?:</u> | <input type="checkbox"/> Home | <input type="checkbox"/> Work |
| | <input type="checkbox"/> Hospital | <input type="checkbox"/> Other _____ |
| <u>How did you get there?:</u> | <input type="checkbox"/> Ambulance | <input type="checkbox"/> Police |
| | <input type="checkbox"/> Drove myself | <input type="checkbox"/> Someone else drove |

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____