Cornerstone Family Chiropractic

Motor Vehicle Accident Report Form

Instructions: Please carefully consider and answer each question as completely as possible

Name_____Today's Date (__/__/__) Date of Accident (__/__/__)
Were you the □ Driver □ Passenger □ Pedestrian
Were you struck from □ Behind □ Right Side □ Left Side □ Front □ Auto was parked □ Other, explain:

_____
Did your car strike the other(s) involved? □ Yes □ No Did the other car strike yours? □ Yes □ No
Were traffic citations issued? □ Yes □ No If "yes", to □ You □ The other driver □ The driver of your car

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Did any part of your body strike any part of the car? □ Yes □ No. If "yes", please explain: _____

_____
Did you have a seat belt on? □ Yes □ No Shoulder strap? □ Yes □ No
Does your car have a headrest? □ Yes □ No Height or position? □ Shoulder □ Neck □ Head □ Above
Loss of consciousness? □ Yes □ No If "yes", please explain: _____

_____
Were you stunned? □ Yes □ No How long? _____
Did you feel or hear popping, tearing, or ripping noise in your neck or back? □ Yes □ No
If "yes", please explain: _____

_____
Did you feel any pain? □ Yes □ No Where? _____
How long after the accident? _____
Did you find any bruises? □ Yes □ No Where? _____
List the extent of injuries as you know them: _____

_____

Instructions: Please check symptoms you have experienced since the accident.

- □ Headaches
- □ Skull or Head Pain
- □ Neck Pain
- □ Neck Stiffness
- □ Head feels too heavy
- □ Shoulder Pain
- □ Shoulder Stiffness
- □ Arm Pain
- □ Arm Numbness
- □ Pins and Needles in Arms
- □ Numbness in Hands/Fingers
- □ Cold Hands
- □ Upper Back Pain
- □ Upper Back Stiffness
- □ Mid Back Pain
- □ Mid Back Stiffness
- □ Chest Pain
- □ Rib Pain
- □ Painful Breathing
- □ Low Back Pain
- □ Low Back Stiffness
- □ Hip Pain
- □ Buttock Pain
- □ Leg Pain
- □ Leg Numbness
- □ Pins and Needles in Legs
- □ Numbness in Feet/Toes
- □ Cold Feet
- □ Depression
- □ Anxiety
- □ Tension
- □ Irritability
- □ Nervousness
- □ Mental Dullness
- □ Loss of Memory
- □ Difficulty Sleeping
- □ Fatigue
- □ Tremors
- □ Face Flushed
- □ Loss of Color
- □ Dizziness
- □ Fainting
- □ Sinus Trouble
- □ Loss of Smell
- □ Eye Strain
- □ Difficulty Focusing
- □ Pain Behind the Eyes
- □ Eyes Sensitive to Light
- □ Double Vision
- □ Buzzing or Ringing in Ears
- □ Loss of Balance
- □ Palpitations
- □ Shortness of Breath
- □ Digestive Problems
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Excessive Perspiration
- □ Loss of Perspiration
- □ Loss of Taste
- □ Cold Sweats
- □ Fever
- □ Pain in Doing Occupation
- □ Swelling. If so, where: _____
- □ Difficulty with:
  - □ Riding in Car
  - □ Bending
  - □ Standing
  - □ Sitting
  - □ Walking
  - □ Lifting
  - □ Twisting and/or Turning
  - □ Rising to Walk

Did you require post accident care or hospitalization? □ Yes □ No If "yes", where: _____
Were you examined? □ Yes □ No If "yes", by whom: _____
Were you X-rayed? □ Yes □ No Was any treatment given? (medication, supports, or recommendations):

_____
What is your occupation? _____
Have you missed work as a result of this accident? □ Yes □ No If "yes", how many days? _____

Insurance Companies Involved

Your Insurance Company _____ Ins. Adjustor Name _____
Other Vehicle Insurance Company _____
Other Vehicle Ins. Adjustor Name _____

Description of Accident

Date of Accident: _____ Time: _____ □ A.M. □ P.M. Weather _____
Road Conditions _____
Streets where accident occurred _____
Your Direction: □ N □ S □ E □ W Other Vehicle Direction: □ N □ S □ E □ W
Your Speed: _____ Other Vehicle Speed: _____
Your Car Type: _____ Other Car Type: _____
Describe the accident in detail: _____
_____
_____
_____
_____
_____
_____

Impact

Head Position: □ Up □ Down □ Left □ Right Braking: □ On □ Off
Awareness: □ Very □ Partial □ None

First Aid

Passenger / Passers By / Police / Aid Car / Ambulance / Hospital / Clinic / Home Care

Name: Location: Assistance:
Comments:
Name: Location: Assistance:
Comments:

Doctor(s) And Treatment

1. _____ Specialty: _____ Diagnostics: _____
Diagnosis: _____ Treatment: _____ Results: _____
2. _____ Specialty: _____ Diagnostics: _____
Diagnosis: _____ Treatment: _____ Results: _____
3. _____ Specialty: _____ Diagnostics: _____
Diagnosis: _____ Treatment: _____ Results: _____

Other Information

Please report any other important information regarding this accident: _____
_____
_____
_____
_____
_____

Patient Signature _____ **Date** _____