DELMARVA CHIROPRACTIC
AND WELLNESS CENTER

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Patient Name:_____ **DOB:**_____
Todays Date:_____

Motor Vehicle Accident Health History Form

Date of Accident:_____ **Approximate Time of Accident**:_____

Make & model of patients vehicle: _____

Year of patients vehicle:_____

Make & model of other vehicle involved?_____ Year:_____

Any additional vehicles involved? **YES** **NO** If yes, how many?_____

Type(s) of vehicles?_____

Were you the: (Circle one)

Driver **Rear passenger (left side)** **Rear middle passenger**

Front seat passenger **Rear passenger (right side)**

Were you restrained by a seatbelt? **YES** **NO**

Did the airbags deploy? **YES** **NO**

Where was your head facing when the collision occurred?

Straight ahead **Looking left** **Looking down**

Looking right **Looking up**

Was the pavement **(WET)** or **(DRY)** at time of accident?

Did your seat have a headrest? **YES** **NO**

Did you make contact with interior of your vehicle? **YES** **NO**

What body parts made contact (if applicable):_____

Where was contact made (ex: dashboard, steering wheel, etc.)?_____

Did you receive a head injury? **YES** **NO**

Patient Name:_____ DOB:_____

How many vehicles struck your car/truck? _____

What is the make and model of their vehicle?_____ Year?_____

Where there any additional vehicles involved in the accident? **YES** **NO** How many?_____

Approximately how fast were you going at the time of impact? _____**MPH**

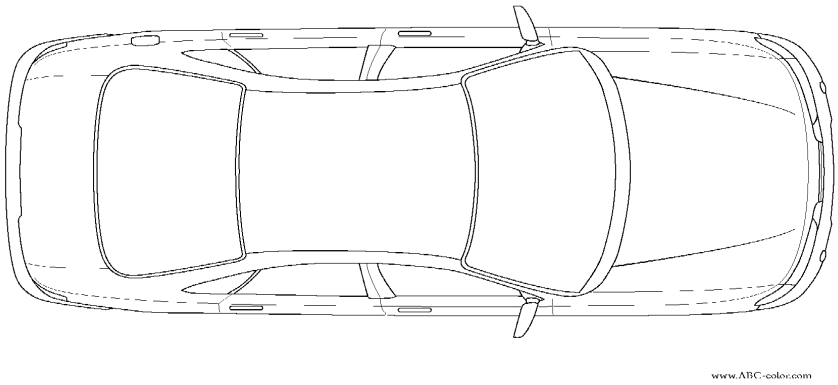
Approximately how fast was the other car going at the time of impact? _____**MPH**

About how far did your vehicle travel after being struck? _____ feet

If your car was standing still at the time of the accident, where were your feet?

Pressed on the brake **Resting on the brake** **Off of the brake**

On the diagram below, please mark the point(s) of impact of your vehicle.



What direction did the impact come from?_____

After the accident, did you strike anything else? **YES** **NO**

If yes, please explain:_____

Was there any damage done to your vehicle?

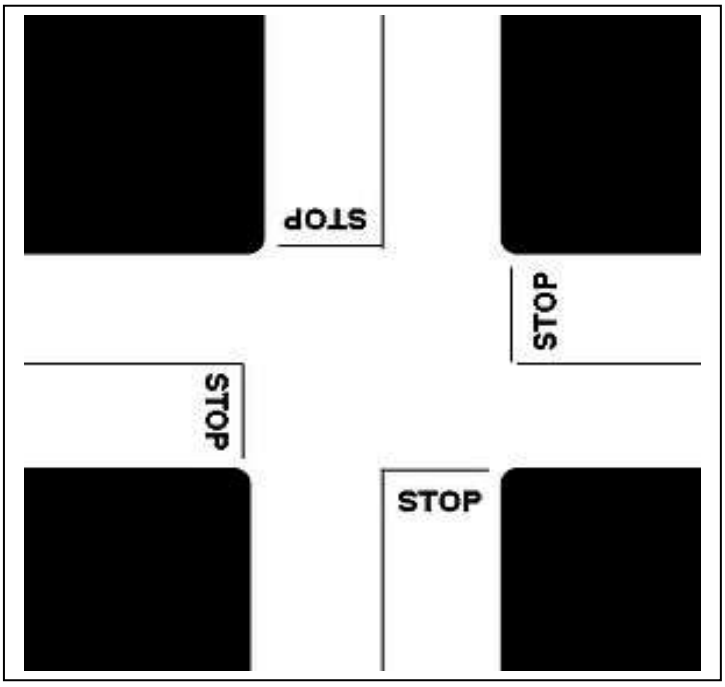
None **Mild** **Moderate** **Totaled**

Was there any damage done to the other vehicle?

None **Mild** **Moderate** **Totaled**

Patient Name:_____ **DOB:**_____

Below, please describe how the accident occurred (in your words). Use the diagram below of an intersection if it's helpful. **Please label your vehicle as #1**



_____

_____

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_____

_____

Was your vehicle towed? **YES** **NO**

Where the police at the scene? **YES** **NO**

Was an accident report created? **YES** **NO**

Did EMS arrive at the scene? **YES** **NO**

Did you go to the hospital after the accident? **YES** **NO**

Did you travel by: **Your Car** **Ambulance** **Other transportation**

How long after the accident did you arrive at the hospital?_____

How did you leave the hospital? **Someone drove me** **I drove myself**

Were x-rays or any other imaging performed? If yes, please explain:_____

_____

Did you receive treatment or any prescriptions/medications at the hospital? If yes, please explain:_____

_____

Patient Name:_____ **DOB:**_____

Other than the hospital, have you visited any other health care provider(s) since the accident? If yes, please explain (please provide names and phone numbers):_____

_____

Were you aware of the collision when it occurred? **YES** **NO**

If yes, did you brace or arms or legs? **YES** **NO**

Did you have any immediate pain from the collision? **YES** **NO**

Please describe discomfort/pain (if applicable)?_____

_____

Where was the pain/symptoms felt?_____

_____

Were you ejected from the vehicle? **YES** **NO**

Did you sustain any injuries outside of your vehicle? **YES** **NO**

Did you suffer from any bruises, cuts, or broken bones as a result of the collision?

YES **NO**

Did you suffer from any of the following additional symptoms? (Circle all that apply)

Dizziness	Difficulty Sleeping
Light headedness	Difficulty with Speech
Severe headaches	Feelings of depression/sadness
Vertigo	Feelings of nervousness/anxiety
Blurry vision	Crying for no reason
Confusion	Ringing in ears
Memory loss	Numbness/Tingling
Extreme drowsiness	Muscle weakness
Difficulty with focus/concentration	Nausea/Vomiting
Sensitivity to light	Visual disturbance
Other:_____	

Patient Name:_____ **DOB:**_____

Have you ever been involved in a motor vehicle accident before? **YES** **NO**

If yes, please answer the five questions below:

1. When and where did the accident(s) occur? A. _____

   B. _____

   C. _____

2. Who did you see for care? A. _____

   B. _____

   C. _____

3. What type of care did you receive? A. _____

   B. _____

   C. _____

4. Did all your symptoms resolve from the above mentioned accidents? **YES** **NO**
   If not, what symptoms persisted? _____
   _____

5. Did any remaining symptoms affect your daily activities in any way? **YES** **NO**

   If yes, please explain: _____
   _____

Patients Name (please print): _____

Patients Signature: _____ Date: _____