



SALAMA CHIROPRACTIC CENTER

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Automobile Accident Information

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? (in dollars) _____
5. What city did the accident occur in? _____
6. What state did the accident occur in? _____
7. What type of impact was the auto accident?
 rear ended hit on drivers side hit another vehicle form behind hit on passenger side
8. Did your vehicle hit anything after the accident? if yes, please describe _____
9. Where were you sitting in the vehicle during the accident?
 driver rear left passenger front passenger rear right passenger
10. Did you know the accident was coming?
 unaware of impending collision aware of impending collision aware of impending collision and I braked
11. What type of vehicle were you in?
 compact car mid size car full size car truck
 SUV minivan van other
12. What type of vehicle impacted yours?
 compact car mid size car full size car truck
 SUV minivan van other
13. At the time of the impact, how fast was your vehicle moving?
 slowing down stopped gaining speed moving steady speed
14. Did you lose consciousness during the accident? yes no
15. Did you have your seatbelt on during the accident? yes no
16. Did you go to the hospital? yes no If no, why and skip 38-43 _____
17. How did get to the hospital?
 ambulance police car walked helicopter drove self other
18. What was the name of the hospital? _____
19. Were you hospitalized over night? yes no
20. Check what you were prescribed at the hospital
 pain medication muscle relaxors neck brace
21. Did you receive any stitches for any cuts at the hospital? yes no
22. Were x rays taken at the hospital? If yes, which area was taken?
 neck skull mid back lower back pelvis hips
 leg knee foot shoulder arm other

Patient Name (print) _____ Date _____

Patient Signature _____