Name _____ Today's Date _____

Date of accident _____

Location of accident _____

Life Line
chiropractic & massage

Please describe the vehicle you were in during the accident.

Vehicle Type
_____ Car
_____ Van
_____ SUV
_____ Pickup Truck
_____ Bus
_____ Other_____

Vehicle Size
_____ Subcompact
_____ Compact
_____ Mid-Sized
_____ Full-Sized
_____ Other_____

Your Position in Vehicle
_____ Driver
_____ Passenger, Front
_____ Passenger, Back-Right
_____ Passenger, Back-Middle
_____ Passenger, Back- Left
_____ Passenger, Third Row

Speed of your Vehicle
_____ Stopped, in gear
_____ Parked
_____ Moving, _____mph

what was the reason
what was the reason?
_____ Traffic Signal
_____ Pedestrian
_____ Stop Sign
_____ Parked
_____ Traffic

Collision Type
_____ Driver's Side Impact
_____ Front Impact
_____ Passenger's Side Impact
_____ Head-On
_____ Pedestrian Incident
_____ Rear Impact

Damage to your vehicle
_____ Minimal damage
_____ Moderate damaged
_____ Severe damage
_____ Totaled
_____ Unsure

Law Enforcement Citations
_____ None issued
_____ Yourself
_____ Driver of the vehicle, while you were a passenger
_____ Driver of the other vehicle
_____ Unsure

Please describe the other vehicle that was involved in the accident.

Vehicle Type
_____ Car
_____ Van
_____ SUV
_____ Pickup Truck
_____ Bus
_____ Other_____

Vehicle Size
_____ Subcompact
_____ Compact
_____ Mid-Sized
_____ Full-Sized
_____ Other_____

What were the conditions at the time of the accident?

Time of Day
_____ Daylight
_____ Dusk
_____ Night

Road
_____ Dry
_____ Damp
_____ Wet

Visibility
_____ Excellent
_____ Good
_____ Fair

_____ Snow Covered _____ Poor
_____ Ice Covered

Please describe the moment of impact during the accident.

Were you,

_____ Completely unaware of the impending accident
_____ Aware of the accident about to occur
_____ Aware of the potential accident, bracing for the impact
_____ Did you have your foot on the brake pedal?

Was your headrest in the

_____ Highest position
_____ Middle position
_____ Lowest position

Air Bag Deployment

_____ Car did not have an air bag
_____ Air bag deployed
_____ Air bag did not deploy

Safety Belts

_____ Lap belt only
_____ Shoulder and lap belt
_____ Not wearing a seatbelt

Position of your head at impact

_____ Facing forward
_____ Tilted forward
_____ Rotated to the left
_____ Rotated to the right

Was your head thrown,

_____ Back, then forward
_____ Forward, then back
_____ To the left
_____ To the left, then right
_____ To the right
_____ To the right, then left

Was your body thrown,

_____ Back, then forward
_____ Forward, then back
_____ To the left
_____ To the left, then right
_____ To the right
_____ To the right, then left
_____ Across the vehicle
_____ Out of the vehicle
_____ Under the vehicle

Position of your body at impact

_____ Straight
_____ Tilted forward
_____ Rotated to the left
_____ Rotated to the right

As a result of the force of the collision,
what part of the vehicle did your body strike?

Head	*Torso*	*Left Arm*
_____ Steering wheel	_____ Steering wheel	_____ Steering wheel
_____ Dashboard	_____ Dashboard	_____ Dashboard
_____ Windshield	_____ Windshield	_____ Windshield
_____ Armrest	_____ Armrest	_____ Armrest
_____ Headrest	_____ Headrest	_____ Headrest
_____ Rear view mirror	_____ Rear view mirror	_____ Rear view mirror
_____ Left door	_____ Left door	_____ Left door
_____ Right door	_____ Right door	_____ Right door
_____ Left window	_____ Left window	_____ Left window
_____ Right window	_____ Right window	_____ Right window
_____ Console	_____ Console	_____ Console
_____ Gear shift	_____ Gear shift	_____ Gear shift
_____ Front seat	_____ Front seat	_____ Front seat
_____ Backseat	_____ Backseat	_____ Backseat

Left Leg	*Right Leg*	*Left Arm*
_____ Steering wheel	_____ Steering wheel	_____ Steering wheel
_____ Dashboard	_____ Dashboard	_____ Dashboard
_____ Windshield	_____ Windshield	_____ Windshield
_____ Armrest	_____ Armrest	_____ Armrest
_____ Headrest	_____ Headrest	_____ Headrest
_____ Rear view mirror	_____ Rear view mirror	_____ Rear view mirror
_____ Left door	_____ Left door	_____ Left door
_____ Right door	_____ Right door	_____ Right door
_____ Left window	_____ Left window	_____ Left window
_____ Right window	_____ Right window	_____ Right window
_____ Console	_____ Console	_____ Console
_____ Gear shift	_____ Gear shift	_____ Gear shift
_____ Front seat	_____ Front seat	_____ Front seat
_____ Backseat	_____ Backseat	_____ Backseat

Your condition and the events directly following the accident.

Did you lose consciousness?	Were you able to walk unassisted?	Numbness or Tingling
_____ Yes	_____ Yes	_____ Yes, where_____
_____ No	_____ No	_____ No

Immediately following the accident, did you feel

	_____ Dizzy	_____ Weak
	_____ Dazed	_____ Nervous

_____ Disoriented _____ Nauseated

Where did you go afterward?

_____ Drove home _____ Drove to work
_____ Was driven home _____ Was driven to work
_____ Drove to the hospital _____ Drove to school
_____ Was driven to hospital _____ Was driven to school
_____ Taken by ambulance to hospital

Hospital Name _____

Date of hospital visit _____

Did you have an xray taken at the hospital? _____ Yes
_____ No

Which xrays did the hospital take?

_____	Head	Shoulder	Lt_____	Rt_____	Hip	Lt_____	Rt_____
_____	Neck	Arm	Lt_____	Rt_____	Thigh	Lt_____	Rt_____
_____	Upper back	Elbow	Lt_____	Rt_____	Knee	Lt_____	Rt_____
_____	Mid back	Wrist	Lt_____	Rt_____	Calf	Lt_____	Rt_____
_____	Ribs	Hand	Lt_____	Rt_____	Ankle	Lt_____	Rt_____
_____	Chest	Fingers	Lt_____	Rt_____	Foot	Lt_____	Rt_____
_____	Abdomen	Buttock	Lt_____	Rt_____	Toes	Lt_____	Rt_____
_____	Low Back						
_____	Pelvis						

Did your major complaints exist before the accident? _____ Yes
_____ No
_____ Remained the same

What areas did you immediately feel pain?

_____	Head	Shoulder	Lt_____	Rt_____	Hip	Lt_____	Rt_____
_____	Neck	Arm	Lt_____	Rt_____	Thigh	Lt_____	Rt_____
_____	Upper back	Elbow	Lt_____	Rt_____	Knee	Lt_____	Rt_____
_____	Mid back	Wrist	Lt_____	Rt_____	Calf	Lt_____	Rt_____
_____	Ribs	Hand	Lt_____	Rt_____	Ankle	Lt_____	Rt_____
_____	Chest	Fingers	Lt_____	Rt_____	Foot	Lt_____	Rt_____
_____	Abdomen	Buttock	Lt_____	Rt_____	Toes	Lt_____	Rt_____
_____	Low Back						
_____	Pelvis						

If you experienced laceration (cuts), where were they located?

_____	Head	Shoulder	Lt_____	Rt_____	Hip	Lt_____	Rt_____
_____	Neck	Arm	Lt_____	Rt_____	Thigh	Lt_____	Rt_____
_____	Upper back	Elbow	Lt_____	Rt_____	Knee	Lt_____	Rt_____
_____	Mid back	Wrist	Lt_____	Rt_____	Calf	Lt_____	Rt_____
_____	Ribs	Hand	Lt_____	Rt_____	Ankle	Lt_____	Rt_____
_____	Chest	Fingers	Lt_____	Rt_____	Foot	Lt_____	Rt_____

_____
_____Abdomen Buttock Lt_____ Rt_____ Toes Lt_____ Rt_____
_____Low Back
_____Pelvis
pain on the day **after** the accident?Where did you experience pain on t
_____Head Shoulder Lt_____ Rt_____ Hip Lt_____ Rt_____
_____Neck Arm Lt_____ Rt_____ Thigh Lt_____ Rt_____
_____Upper back Elbow Lt_____ Rt_____ Knee Lt_____ Rt_____
_____Mid back Wrist Lt_____ Rt_____ Calf Lt_____ Rt_____
_____Ribs Hand Lt_____ Rt_____ Ankle Lt_____ Rt_____
_____Chest Fingers Lt_____ Rt_____ Foot Lt_____ Rt_____
_____Abdomen Buttock Lt_____ Rt_____ Toes Lt_____ Rt_____
_____Low Back
_____Pelvis Next day discomfort_____Increased
_____Decreased

As a result of the accident, did you have to take time off from work or school?
_____Yes, dates missed _____ _____No

Did you retain an attorney? Yes_____ No_____

Attorney's information
Name _____
Address _____
_____
Phone _____

Your insurance information
Name _____
Address _____
_____
Phone _____
Claim # _____
Contact Person _____

Other driver's insurance
Name _____
Address _____
_____
Phone _____
Claim # _____
Contact Person _____

_____ _____
Signature Date