DeFalco
Family Chiropractic

Automobile Accident Injury Information:

Date:_____

Patient Name:_____ Patient Struck as a Pedestrian:_____

Date of Accident:_____ Time:_____ AM/PM

Pt. Speed was: Stopped Accelerating Slowing Constant Road Conditions:_____

Pt. Vehicle:_____ Other Vehicle:_____

Where was Vehicle Struck:_____ Where Pt. was Sitting:_____

Airbags Deployed: YES / NO Seat Break: YES / NO Aware prior to Impact: YES / NO
Seatbelt: YES / NO Brake On: YES / NO Head Restraint: YES / NO

Hand Position at Impact:_____ Body Position at Impact:_____
Head Position at Impact:_____ Loss of Consciousness:_____

Where did you go after the accident: ER / MD / DC / Work / Home If MD what kind:_____
How did you get there: Self / Friend / Ambulance Time Missed from Work:_____
Treatments Receive:_____

Location of Accident:_____
_____

Police at Crash Site: YES / NO Police Report: YES / NO

Estimated Damage to Pt. Vehicle:_____ Other Vehicle:_____

Attorney:_____ Phone:_____

Description of Accident:

_____
_____
_____
_____
_____
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