Zindt Chiropractic Center
3819 S M St
Tacoma, WA 98418

Vehicle Accident Info

Patient Information

Name_____Date_____
Last Name First Name Middle Initial

Date of Accident_____ Time of Accident_____☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian How many people were in your vehicle?_____

Have you hired an attorney? YES / NO If yes, whom_____ Phone#_____

Accident Site

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other

Which direction were you headed?_____

Speed you were traveling?_____

Vehicle

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?
☐ Low ☐ Midposition ☐ High

Impact

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle? ☐ Yes

☐ No If yes, explain_____

Was impact from:

☐ Font ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up ☐ Looking back

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐Left

Were you: ☐ Surprised by impact ☐ Braced for impact

Other Vehicle

Make/Model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

Police

Did the police come to accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No
If yes, to whom_____

Patient Condition

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident: _____

_____

_____

Treatment

Did you go to the hospital? ☐ Yes ☐ No How did you get to the hospital? ☐ Ambulance ☐ Private Transportation

When did you go? ☐ Immediately after the injury ☐ The next day ☐ 2 or more days after injury ☐ Other:_____

Name of Hospital?_____ Name of Doctor?_____

Diagnosis:_____

_____

Treatment received:_____

X-rays taken:_____ CT-Scan:_____ MRI:_____

Symptoms/Injuries

Have you been able to work since this injury? ☐ Yes ☐ No How many hours have you missed?_____

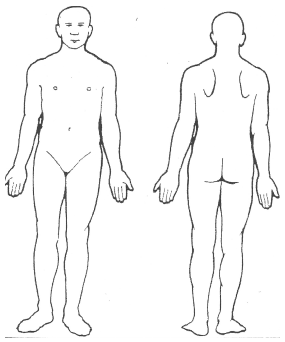
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/Shoulder pain	☐ Feet/Toe Numbness	☐ Neck Pain
☐ Back Pain	☐ Hand/Finger Numbness	☐ Neck Stiffness
☐ Back Stiffness	☐ Headaches	☐ Shortness of Breath
☐ Chest Pain	☐ Irritability	☐ Sleep Difficulty
☐ Dizziness	☐ Jaw Problems	☐ Stomach Upset
☐ Ear Buzzing	☐ Leg Pain	☐ Tension
☐ Ear Ringing	☐ Memory Loss	☐ Nausea
☐ Fatigue	☐ Vision Blurred	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain:	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Sharp

How often do you have this pain?_____ Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other_____

Movements that are painful to perform include: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending ☐ Twisting

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my chiropractic evaluation at Zindt Chiropractic Center at this time.

Patient's Signature _____ Date_____

Signature of Parent/Guardian_____ Relationship_____