DR. TREVOR O. ERIKSEN, B.A., D.C.
4600 Kietzke Lane, Bldg E, Suite 145 Reno, NV 89502 (775) 772-7961

AUTOMOBILE ACCIDENT HISTORY FORM

Patient Name _____ Today's Date _____

Date of Accident: _____ Time of Accident: _____ ☐ A.M. ☐ P.M.

City of Accident: _____ Street of Accident: _____

Road Conditions at Time of Accident: ☐ Wet ☐ Dry ☐ Icy ☐ Other: _____

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

Were you taken to a hospital? ☐ Yes ☐ No

If "Yes" please list the name and city of the hospital. _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

_____

The following questions pertain to you, the patient, and the vehicle you were in:

1. Where were you seated in the vehicle? _____
2. Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? _____
3. Did you lose consciousness (black out) upon impact? ☐ Yes ☐ No
4. If you did lose consciousness, estimate for how long. _____
5. How far is the top of the headrest or seatback from the top of your head?
   (approximately) _____ inches ☐ Above ☐ Below
6. Were you wearing a seatbelt? ☐ Yes ☐ No
   If "Yes", please check what kind: ☐ Lap Seatbelt ☐ Shoulder Lap Seatbelt
7. List the year, make and model of the vehicle you were in:
   Year _____ Make _____ Model _____
8. Was your car stopped at the time of impact? ☐ Yes ☐ No
   If "Yes", was the driver's foot also on the brake? ☐ Yes ☐ No
   If "No", estimate the speed of the vehicle you were in _____ M.P.H.
9. If the vehicle was moving at the time of impact, was it:
   ☐ Slowing Down ☐ Gaining Speed ☐ Traveling at a Steady Rate of Speed

10. Please describe to the best of your knowledge what happened during this accident:

_____

_____

_____

_____

11. What bleeding cuts did you get during this accident? _____

_____

_____

12. What bruises did you get during this accident? _____

_____

_____

13. On what part of the auto did the following body parts hit?
    A. Head Hit _____
    B. Chest Hit _____
    C. ☐ Right/☐ Left Shoulder Hit _____
    D. ☐ Right/☐ Left Arm Hit _____
    E. ☐ Right/☐ Left Hip Hit _____
    F. ☐ Right/☐ Left Leg Hit _____
    G. ☐ Right/☐ Left Knee Hit _____
    H. Other _____

!4. What is the cost damage to the vehicle you were in? _____

15. What of the following car parts broke during the accident?
    ☐ Windshield ☐ Right/☐ Left Side Window ☐ Steering Wheel ☐ Front Seat Back
    ☐ Other _____ ☐ Other _____

16. Was the trunk of your body pointed straight forward at the time of the collision? ☐ Yes ☐ No
    If "No", what direction was it turned, and by how much? _____

17. Was your head pointed straight forward? ☐ Yes ☐ No
    If "No", what direction was it turned, and by how much? _____

The following questions pertain to the other vehicle involved in the accident:

1. What was the year, make and model of the other vehicle?
    Year _____ Make _____ Model _____

2. Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No
    If "Yes", what was its approximate speed? _____ M.P.H.

3. If the other vehicle was moving at the time of collision, was it:
    ☐ Slowing Down ☐ Gaining Speed ☐ Traveling at a Steady Rate of Speed

If you have been in previous auto accidents, please list the year and injuries for each accident:

1. _____
2. _____
3. _____
4. _____
5. _____