Murfreesboro Family Chiropractic Rehabilitation, PLLC.

Accidental Injury Information

Please Print

Patient Name _____ **D.O.B.** _____ **Date** _____

Basic Information about the Accident:

Date Accident Occurred or Started:

___/___/___

Time of Day when Accident Occurred or Started:

_____ AM or PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Work Accident Specific Information:

Complete only if this injury is work related:

- ☐ **Did the accident occur on the premises of the facility where you normally work? (i.e. local work address?)**
- ☐ **Did the accident occur during your normal working hours?**
- ☐ **Did you report the accident to your employer?**
- ☐ **Is your employer covered by Worker's Compensation Insurance under state law?**
- ☐ **Has your Employer prepared an initial written report?**
- ☐ **Does the Employer's Report describe the condition or symptoms you are experiencing?**
- ☐ **Has a claim number been issued for this accident?**
- ☐ **Have you received any written denial of liability from either your employer or Worker's Insurance Comp Payer?**

Signed _____ **Date** ___/___/___

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Accidental Injury Information

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Patient Name _____ **D.O.B.** _____ **Date** _____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage amount estimate: $ _____ ☐ Minor ☐ Major ☐ Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage amount estimate (other car): ☐ Minor ☐ Major ☐ Totaled

Where did the accident happen? Street names: _____ City/State: _____

Was it: ☐ Controlled Intersection ☐ Uncontrolled Intersection ☐ Not Intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Weather Conditions: ☐ Sunny ☐ Rainy ☐ Cloudy

Street Surface ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other _____

Type of Impact ☐ Rear End ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on Impact ☐ Locked Tight ☐ Loosely Applied ☐ Foot Not on Brake

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Where were you seated in the vehicle? _____ Seat belt? ☐ Yes ☐ No

Shoulder Harness ☐ Yes ☐ No Headrest ☐ Yes ☐ No Headrest position: ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No Did they deploy? ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact, were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other _____

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part _____

What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of consciousness? ☐ Yes ☐ No How long? _____

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital? _____ How long? _____

Taken by ambulance? ☐ Yes ☐ No X-rays taken? ☐ Yes ☐ No

X-ray areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other: _____

Medication given: ☐ Yes ☐ No RX: _____

Other instruction? _____ Follow-up: _____

Was a police report filed? ☐ Yes ☐ No

How fast was your vehicle traveling? _____ mph How fast was the other vehicle traveling? _____ mph

Did the pain exist before the accident? ☐ No ☐ Yes If yes, explain: _____

Signed _____ **Date** ____/____/____