

BELL PLAZA CHIROPRACTIC
1052 E. EL CAMINO REAL, SUNNYVALE, CA 94087
(408) 248-7960
AUTOMOBILE ACCIDENT HISTORY FORM

Your Name _____ Today's Date _____

Date of Accident _____ Time of Accident _____ a.m. / p.m.

City of Accident _____ Street of Accident _____

Road conditions at the time of accident: WET DRY ICY OTHER _____

Did the police come to the scene of the accident? NO YES: Is there a report? NO YES

Did you go to the hospital? NO YES: Complete the following:

What is 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? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during the accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise? SURPRISE AWARE

Did you lose consciousness (black out) upon impact? NO YES: How long? _____

Did you experience a flash of light or explosion in your head? NO YES

Did you become any of the following due to the accident?

CONFUSED DISORIENTED LIGHT HEADED DIZZY
NAUSEATED BLURRED VISION RING/BUZZ IN EARS

If you still have any of the symptoms above, which one? _____

Are you currently suffering from any of the following:

RESTLESSNESS DIFFICULT CONCENTRATING
IRRITABLE DIFFICULT WITH MEMORY
SLEEPLESSNESS REDUCED TOLERANCE TO HEAT
FORGETFULNESS REDUCED TOLERANCE TO ALCOHOL

How far is the top of the headrest or seatback from the top of your head

(Approximately): ___ Inches ABOVE BELOW

Were you wearing a seatbelt? NO YES

If yes, was it a LAP seat belt, or a SHOULDER/LAP seat belt?

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List the type of vehicle you were in:

Year _____ Make _____ Model _____

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, then estimate the speed of the vehicle you were in: _____m.p.h.

If your vehicle was moving at the time of impact, was it:

Slowing down? YES NO

Gaining speed? YES NO

Traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?

Head hit _____ Chest hit _____

Right/left shoulder hit _____ Right/left arm hit _____

Right/left hip hit _____ Right/left leg hit _____

Right/left knee hit _____ Other _____

Did you receive any injury or bruise from the seat belt? YES NO

If yes, then describe _____

What is the estimated cost damage to the vehicle you were in? \$ _____

Which of the following car parts broke during the accident?

WINDSHIELD

FRONT SEAT BACK

RIGHT/LEFT SIDE WINDOW

STEERING WHEEL

OTHER _____ OTHER _____

Was the trunk of your body pointed straight forward at the time of the collision?

YES NO: How was it turned? _____

List the type of other vehicle:

Year _____ Make _____ Model _____

Was the other vehicle moving at the time of collision? YES NO

If yes, what was its approximate speed? _____m.p.h.

If the other vehicle was moving at the time of collision, was it:

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

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