Steven M. Gillis, D.C.

Accident Information **Patient Name:**_____**Date**_____

What was the date of the accident?_____ __Time of accident?_____

Briefly describe how the accident occurred:

Were you seen by paramedics or taken immediately to the hospital?

Current complaints (how you feel today):
1.

2.

3.
Other:
Rate each complaint with a number 0 to10. 0= no pain, 10 =unbearable pain
Also, note the quality of the pain i.e., sharp, dull, ache, numbness etc.

How often are your symptoms present for each complaint?
□ 0-25% of the time □ 26-50% □ 51-75% □ 76-100%

What do your current injuries/complaints prevent you from doing that you were able to perform before the accident? i.e., workout, work, lift, sit or stand long periods etc.

Did you see any doctors, ER or receive treatment for these injuries? When?
If yes, please list:

Have you had any spinal x-rays, MRI, CT scan?
If yes, when taken

Did you have any of these complaints or received treatment for any of these complaints before the accident?

Are you taking any medications for these complaints?

ABOUT THE ACCIDENT:
Did you have your seatbelt on during the accident? – Yes / No
Did the airbag deploy? Yes / No

How many vehicles were involved in the accident?_____

What was the estimated damage to the vehicle you were in? _____

What road or intersection were you on when the accident occurred?
_____

What direction were you traveling in? _____

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What city and state did the accident occur in? _____

Your position in the vehicle during the accident: driver / passenger front/ rear

Did you know the accident was coming?_____

What type of vehicle were you in? _____

What type of vehicle impacted yours? _____

At the time of the impact, how fast was your vehicle moving? _____

At the time of impact, how fast was the other vehicle moving? _____

During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

What was damaged in your vehicle? (Circle all that apply)

- windshield
- steering wheel
- dashboard
- seat frame
- side window
- rear window
- rear bumper
- front bumper
- trunk
- front left door
- front right door
- back left door
- mirror
- knee bolster
- back right door
- completely totalled
- other:

Did you lose consciousness during the accident? - yes - no

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

How were your hands positioned during the accident? _____

Did your head hit anything during the accident? -no - yes, please describe_____

Did any part of your body hit anything during the accident? -no - yes, please describe_____

What kind of headrest was in your vehicle?

- movable fixed headrest
- nonmovable fixed headrest
- no headrest

Where was the headrest positioned on your head? _____

Anything else we should know?

IF INVOLVED IN
ACCIDENT THE FOLLOWING
INF. IS NEEDED

ATTORNEY INFORMATON

ATTORNEY NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

YOUR AUTO INSURANCE INFORMATION

COMPANY NAME & NUMBER: _____

POLICY#/ CLAIM#: _____

ADJUSTER NAME & NUMBER: _____

THIRD PARTY INFORMATION

COMPANY NAME & NUMBER: _____

POLICY#/ CLAIM#: _____

ADJUSTER NAME & NUMBER: _____