Offering Programs of Hope and Healing

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MOTOR VEHICLE ACCIDENT CASE RECORD

NAME_____ TODAY'S DATE_____

1. DATE of INJURY_____ TIME of INJURY_____
2. WHERE did ACCIDENT HAPPEN? _____
_____

3. BRIEF STATEMENT as to how ACCIDENT OCCURRED _____
_____
_____
_____

4. Were there ANY CHARGES ARISING from the ACCIDENT? NO___YES___*if yes, who was charged with causing the accident?* _____

5. TYPES of VEHICLE(s) INVOLVED in the ACCIDENT:_____
_____

6. Would you describe the accident as a:
   a) single vehicle b) multi-vehicle c) chain reaction d) roll over e)car/pedestrian

7. What was the POINT OF IMPACT on your vechicle: (Circle as many as apply)
   a) head-on b) rear-ended c) rt. front d) lt. front e) rt side
   f) lt. side g) rt. rear h) lt rear I) totalled, vehicle written off

8. POSITION OF PATIENT: Driver ___ Mid ___ Co-driver ___
   Passenger in rear seat Rt ___ Ct ___ Lt___

9. Were YOU wearing a SEATBELT? YES ___ NO ___
   Shoulder restraint? YES___NO___

10. Was the HEADREST high enough to restrain the backward motion of your head?
    YES___ NO___
11. What was the total number of occupants in your vehicle? _____

12. Was anyone else injured? NO___YES___ if yes, state extent of injuries:
    a) minor____ b) moderate ____ c) Severe _____
    Note:_____

13. What occurred as a result of the impact? (*Circle as many as apply)*
    A) Tensed body for impact B) Neck whipped forward and back
    C)Body wrenched sideways D) Thrown from seat
    E) Vehicle rolled over F) Vehicle propelled into another vehicle
    G) Vehicle Spun H) Thrown from Vehicle
    I) Vehicle was crushed, patient was trapped inside

14. What would you estimate the speed of the vehicle
    a) that struck you? _____Km/hr b) when you struck? _____ Km/hr.

15. Was your vehicle:
    Parked ____ Stationary *(foot on brake)*____ Slowly rolling ____
    Making a corner ____ driving highway speeds _____ driving city speeds ____

16. Did you strike anything on impact?

    a) NO b) windshield c) steering wheel d) dash
    e)side glass f) roof g) rear window h) objects lose in vehicle

17. SYMPTOMS *(how you felt <u>immediately</u> following the accident) (Circle as many a apply)*

    A. a) Normal b) Confused c) dazed d)numbed e) shock f) disassociated
    g) stupor

EXPLAIN _____

    B. a) Normal consciousness b) unconscious c) loss of awareness d) disoriented
    e) cold sweat f) faint g) numbness h) tingling i) other
    _____

    C. If other than normal: (i) which symptom(s) _____
    (ii) how long did symptom(s) last _____
    D. Did you experience any loss of motor control? NO ___ YES___ if yes, in what area(s)? _____

    E. Did you experience any:
    NAUSEA: NO____ YES____ VOMITING: NO___ YES ___

    F. Did you experience any: (i) visual disturbance: NO___ YES___
    (ii) Ringing in the ears: NO___ YES___
    (iii) Immediate pain: NO___ YES___ if yes, where?

G. Did you experience any: (i) cuts NO___ YES ____ where?_____
(ii) scrapes NO___ YES___ where? _____
(iii) cuts requiring stitches NO ___ YES___ where?
_____
(iv) broken bones NO___ YES___ if yes, where?
_____

18. CARE OR TREATMENT TO DATE
A) On the day of the accident were you:
(i) taken to the hospital by ambulance NO ___ YES___if yes, which hospital?
_____
(ii) at the hospital, what was the course of examination?
Physical exam ___ x-rays ___
other_____
(iii) Do you know who examined you? NO___ YES___ if yes, please state __
_____
(iv) Were you: Admitted to hospital NO___ YES___
Released after examinations YES___ NO ___

B) On the day of the accident were you taken to: *(other than ambulance)*
Emergency ___ Medicentre ___ Family doctor ___ This office ___
Another chiropractor ___ your home ___ Phoned for advice ___ Resumed activities ___

19. Have you been examined by ANYONE since the accident ? NO ___ YES ___ *if yes, complete the following:*
A.
a) Name_____ Type of Practice _____
b) Diagnosis or Explanation Provided
_____
c) Treatment provided
_____
d) Dates of appointments
_____
e) Outcomes: (i) improvement (ii) no change (iii)worse (iv) complications

B.
a) Name_____ Type of Practice _____
b) Diagnosis or Explanation Provided
_____
c) Treatment provided
_____
d) Dates of appointments
_____
e) Outcomes: (i) improvement (ii) no change (iii)worse (iv) complications

C.

a) Name_____ Type of Practice _____
b) Diagnosis or Explanation Provided
_____
c) Treatment provided
_____
d) Dates of appointments
_____
e) Outcomes: (i) improvement (ii) no change (iii)worse (iv) complications

D.

a) Name_____ Type of Practice _____
b) Diagnosis or Explanation Provided
_____
c) Treatment provided
_____
d) Dates of appointments
_____
e) Outcomes: (i) improvement (ii) no change (iii)worse (iv) complications

20. Did you have any previous condition that may have made you more vulnerable to this accident? NO___ YES___ if yes, please state:

_____
_____
_____

21. Describe your chief complaints since the time of the accident until the present time:

_____
_____
_____
_____

22. Rate your usual level of pain by circling a number on the following scale:

No pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating pain

23. To date do you feel your injuries arising from this accident are:
(a) improving (b) good days, bad days (c) same (d) worse in some areas (e) overall (f) worse

24. Due to the accident did you lose any Personal Belongings: ie. glasses, etc.
NO___ YES___
if yes, please state _____

25. Have you consulted a lawyer? NO___ YES___

26. Have you been contacted by an insurance adjustor? NO ___ YES___ if yes, which company?

Name of adjustor _____ Company _____

27. Have you contacted your own insurance agent? NO___ YES___

Name of Your Insurance Company _____

28. Have you had any time loss from work due to this accident? NO ___ YES___ if yes, give dates of time loss: from :_____ to _____

29. Has the accident produced pain that has compromised your work/home duties? NO___YES___

If yes, please describe:

_____
_____
_____

Extra notes:

_____
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