ESTNER
INJURY CENTERS
Chiropractic | Physiotherapy

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VEHICLE ACCIDENT INFORMATION

Patient Information

Patient Name _____ Date _____

Date of Accident _____ Time of Accident _____ AM or PM

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian □ Motorcycle Operator

How many total occupants were in your vehicle? _____

Accident Site & Impact

Road/Street Name _____ City/State _____

Estimated speed you were traveling _____

Did your car impact another vehicle? □ Yes □ No Did your car impact anything else? □ Yes □ No

Did any part of your body strike anything in the vehicle? □ Yes □ No If yes, explain _____

Was the impact from : □ Front □ Rear □ Left □ Right □ Other _____

Patient Condition and Treatment

Were you unconscious immediately after the accident? □ Yes □ No If yes, for how long?_____

Please decribe how you felt immediately after the accident: _____

_____

Did you go to the Hospital or Urgent Care? □ Yes □ No / When did you go? □ Immediatley after accident □ Next Day □ Other

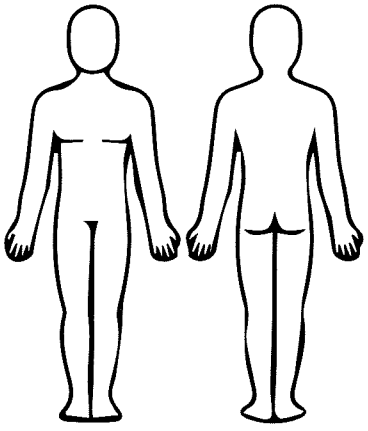
Name of Facility: _____ Treatment Received_____

Symptoms & Injuries

Have you been able to work since this injury? □ Yes □ No How many days of work have you missed? _____

If you have had any following symptoms since your injury, please check the box:

□ Arm/Shoulder Pain	□ Feet/Toe Numbness	□ Neck Pain	□ Ear Buzzing
□ Back Pain	□ Hand/Finger Numbess	□ Neck Stiff	□ Ear Ringing
□ Back Stiffness	□ Headaches	□ Shortness of breath	□ Fatigue
□ Chest Pain	□ Irritability	□ Sleep Difficulty	□ Leg Pain
□ Dizziness	□ Jaw Problems	□ Stomach Upset	□ Memory Loss
□ Vision Blurred	□ Tension	□ Nausea	



Please mark the picture where you continue to have pain, numbness, tingling →

Does it interfere with your : □ Work □ Sleep □ Daily Routine □ Recreation

Movements that are painful to perform: □ Sitting □ Standing □ Walking

□ Bending □ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representitive Date

_____ _____

Please Print name of Patient, Parent, Guardian, or Personal Representitive Relationship to Patient