

**Lenz Chiropractic, PC**  
**Automobile Accident History Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ am pm

Location: \_\_\_\_\_

Describe the accident in your own words: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Road conditions at the time of accident:**  Wet  Dry  Icy  Snow  Other: \_\_\_\_\_

**You were the:**  Driver  Passenger  Pedestrian **Passenger position:**  Front  R rear  L rear

**The impact was from:**  Front  Right side  Left side  Rear

**At impact you were facing:**  Straight-ahead  Right  Left

**Were you aware of the approaching collision prior to impact or were you surprised?**  Aware  Surprised

**Did you experience a flash of light or a feeling of explosion in your head?**  Yes  No  Can't remember

**Immediately following the accident, did you become:**

Confused  Disoriented  Light-headed  Dizzy  Nauseous  Blurred vision  Ring in ears

**Were your hands on steering wheel?**  Yes  No **Foot on Brake?**  Yes  No

**Were you braced for impact?**  Yes  No **Seat belts on?**  Yes  No

**If you have an airbag in your car, did it inflate on impact?**  Yes  No  N/A

**Shoulder restraint – was it shoulder/lap combination?**  Yes  No

**Did you receive any injury or bruise from the seatbelt?**  Yes  No If yes, describe: \_\_\_\_\_

**Did you strike anything in vehicle at impact?**  Yes, specify \_\_\_\_\_  No

**Did you lose consciousness?**  Yes  No If yes, how long? \_\_\_\_\_

**Name(s) of other people in your car:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Was there police investigation at the scene?**  Yes  No **Citation issued?**  Yes  No **To whom?** \_\_\_\_\_

**Did you go to a hospital/emergency center?**  Yes  No If yes, where: \_\_\_\_\_ when: \_\_\_\_\_

**How did you get to hospital?** \_\_\_\_\_ **Name of attending doctor?** \_\_\_\_\_

**Treatment rendered:** \_\_\_\_\_ **Release same day?**  Yes  No If no, when: \_\_\_\_\_

**Doctor's recommendations, if any:** \_\_\_\_\_

**Have you seen any other doctor as a result of this accident?**  Yes  No **Dr.'s name:** \_\_\_\_\_

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**CHECK SYMPTOMS YOU HAVE HAD SINCE ACCIDENT:**

<input type="checkbox"/> Headache	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hip pain	L R ○ ○	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Leg pain	○ ○	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Feet cold
<input type="checkbox"/> Neck stiff	<input type="checkbox"/> Stomach upset	<input type="checkbox"/> Knee pain	○ ○	<input type="checkbox"/> Depression	<input type="checkbox"/> Hands cold
<input type="checkbox"/> Fever	<input type="checkbox"/> Head heavy	L R <input type="checkbox"/> Ankle pain	○ ○	<input type="checkbox"/> Lights bother eyes	<input type="checkbox"/> Regional swelling
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Arm pain	○ ○	<input type="checkbox"/> Foot pain	○ ○	<input type="checkbox"/> Face flushed
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Elbow pain	○ ○	<input type="checkbox"/> Pins & needles in arm	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Urinary difficulties
<input type="checkbox"/> Cold sweats	<input type="checkbox"/> Wrist pain	○ ○	<input type="checkbox"/> Pins & needles in leg	<input type="checkbox"/> Fainting	<input type="checkbox"/> _____
<input type="checkbox"/> Tension	<input type="checkbox"/> Hand pain	○ ○	<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> _____
<input type="checkbox"/> Ears ring	<input type="checkbox"/> Shoulder pain	○ ○	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> _____

Has this part been injured before?  Yes  No If yes, has this part been injured before? Please describe:

\_\_\_\_\_

\_\_\_\_\_

**Have you lost any time from work because of this accident?**  Yes  No Dates: From \_\_\_\_\_ To \_\_\_\_\_

Totally disabled from \_\_\_\_\_ to \_\_\_\_\_ Partially disabled from \_\_\_\_\_ to \_\_\_\_\_

**Are you currently suffering from any of the following:**  Mental function difficulties or changes

- Restlessness                       Irritable                       Difficulties concentrating     Difficulties with memory
- Difficulties sleeping               Forgetfulness               Reduced tolerance to heat     Intolerance to alcohol

List the year, make and model of the vehicle **you** were in: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

**Was your car stopped at the time of impact?**  Yes  No, estimated speed of vehicle you were in: \_\_\_\_\_ MPH

If your vehicle was moving at the time of impact, was it:  Slowing down  Speeding up  Maintaining speed

Estimated damage to the vehicle you were in: \$ \_\_\_\_\_

List the year, make, and model of the **other** vehicle involved in the accident: Year: \_\_\_\_\_

Make: \_\_\_\_\_ Model: \_\_\_\_\_

**Was the other vehicle moving at time of impact?**  Yes  No If yes, what was approximate speed? \_\_\_\_\_ MPH

Was the other car:  Slowing down  Speeding up  Maintaining steady speed

Any other comments about accident or injuries: \_\_\_\_\_

Your auto insurance company: \_\_\_\_\_ Address \_\_\_\_\_ Policy # \_\_\_\_\_

Other driver's insurance co. \_\_\_\_\_ Address \_\_\_\_\_ Policy # \_\_\_\_\_

Have you been contacted by an insurance adjustor or company representative on this claim?  Yes  No

Have you filled out your Personal Injury Protection (PIP) Application since the accident?  Yes  No

Do you have an attorney who has advised you in this case?  Yes  No Name: \_\_\_\_\_

*I hereby authorize Lenz Chiropractic, PC to release medical information necessary to process this claim.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_