

**CAROLINA CHIROPRACTIC
ACCIDENT/INJURY INFORMATION**

Name: _____ Date: _____

Date of Accident: _____ Time: _____ AM/PM (Please Circle One)

Location of Accident: _____

Type of Accident (Please Circle One): Auto Workman's Comp. Other

(In your own words) Please describe how accident happened: _____

If Auto Accident, were you: the Driver a Passenger (Please circle one)

If a Passenger, were you seated: in front in back (Please circle one)

Were you wearing a seat belt? Yes No (Please circle one)

Did you strike any of the following? (Please circle):

Dash Steering Wheel Windshield Window Back of front seat Door Console

Did any objects strike you? Yes No (Please circle one) If yes, please explain:

Were you thrown from the vehicle? Yes No (Please circle one) If yes, please explain:

Who was cited for the accident? (Please circle one):

You Driver of other vehicle Driver of vehicle that you were in

Were you attended at the scene by paramedics? Yes No (Please circle one)

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Were you transported to any facility for medical attention? Yes No (Please circle one)

If yes, were you transported by ambulance? Yes No (Please circle one)

If yes, what Physician attended to you? _____

What tests were performed? _____

Were x-rays taken? Yes No (Please circle one)

What diagnoses, if any, were given to you? _____

Please list any supports, braces, casts, etc., you were prescribed or fitted with: _____

Did you have any physical handicaps, impairments or disabilities prior to this accident?
Yes No (Please circle one) If yes, please explain: _____

I acknowledge that the information I have provided in these forms is accurate and true to the best of my knowledge and recollection.

Patient Signature

Date

Parent/Guardian Signature

Date