align
Health & Wellness

MOTOR VEHICLE ACCIDENT CASE RECORD

Name _____ Today's Date (D/M/Y) _____

1. Date of injury (D/M/Y) _____ Time of injury _____

2. Where did the accident happen? _____

_____

3. BRIEF statement as to how the ACCIDENT OCCURRED_____

_____

_____

4. Where 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:

☐ Single vehicle ☐ Multi vehicle ☐ Chain reaction ☐ Car/pedestrian

7. What was the POINT OF IMPACT on your vehicle: (identify as many as apply)

☐ Head-on ☐ Rear-ended ☐ Rt. front ☐ Lt. front ☐ Rt. side

☐ Lt. side ☐ Rt. rear ☐ Lt. rear ☐ Totaled, vehicle written off

8. POSITION of the 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 their injuries:

☐ Minor ☐ Moderate ☐ Severe, note: _____

13. What occurred as the result of the impact? (identify as many as apply)

☐ Tensed body for impact ☐ Neck whipped forward and back ☐ Body wrenched sideways

☐ Thrown from seat ☐ Vehicle propelled into another vehicle ☐ Vehicle rolled

☐ Vehicle spun ☐ Vehicle was crushed, patient was trapped ☐ Patient thrown from vehicle

14. What would you estimate the speed of the vehicle

☐ That struck you? _____ Km/hr ☐ 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? ☐ NO ☐ Windshield ☐ Steering wheel ☐ Dash

☐ Side glass ☐ Roof ☐ Rear window ☐ Objects lose in the vehicle

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

A. ☐ Normal ☐ Confused ☐ Dazed ☐ Numbed ☐ Shock ☐ Disassociated ☐ Stupor

EXPLAIN _____

B. ☐ Normal consciousness ☐ Unconscious ☐ Loss of awareness ☐ Disoriented ☐ Cold sweat

☐ Faint ☐ Numbness ☐ Tingling ☐ Other _____

C. If other than normal, how long did the symptom(s) last: _____

D. Did you experience any loss of motor control? ☐ NO ☐ YES

if yes, in what areas?_____

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, if yes, where? _____

(ii) Scrapes: ☐ NO ☐ YES, if yes, where? _____

(iii) Cuts requiring stitches: ☐ NO ☐ YES, if 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 by ambulance? ☐ NO ☐ YES, if yes, which hospital?_____

(ii) At the hospital? ☐ NO ☐ YES, if yes, what was the course of examination?

☐ Physical exam ☐ X-Ray ☐ Other _____

(iii) Do you know who examined you? ☐ NO ☐ YES, if yes, please state _____

(iv)Were you: Admitted to hospital: ☐ NO ☐ YES Released after examination: ☐ NO ☐ YES

B. On the day of the accident were you taken to: (other than by ambulance)

☐ Emergency ☐ Medicentre ☐ Family Doctor ☐ This office

☐ Another Chiropractor ☐ Your home ☐ Phoned for Advise ☐ 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) Date of appointments _____

e) Outcome: ☐ improvement ☐ no change ☐ worse ☐ complications

B. a) Name _____ Type of practice _____

b) Diagnosis or Explanation provided _____

c) Treatment provided _____

d) Date of appointments _____

e) Outcome: ☐ improvement ☐ no change ☐ worse ☐ complications

C. a) Name _____ Type of practice _____

b) Diagnosis or Explanation provided _____

c) Treatment provided _____

d) Date of appointments _____

e) Outcome: ☐ improvement ☐ no change ☐ worse ☐ complications

D. a) Name _____ Type of practice _____

b) Diagnosis or Explanation provided _____

c) Treatment provided _____

d) Date of appointments _____

e) Outcome: ☐ improvement ☐ no change ☐ worse ☐ 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:

☐ Improving ☐ Good days, bad days ☐ Same ☐ Worse in some areas ☐ Overall 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, please state:

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: _____

_____

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Extra notes:

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Name (signature): _____ Date: _____