SAVING LIVES NATURALLY

Jeffrey Arnel, D.C.
drarnelj@aol.com
www.DrJeffArnel.com

Arnel Family Chiropractic

233 Boston Post Road
Orange, CT 06477
(203) 799-1234

Vehicle Accident Information Form

Patient Name: _____

1. What was the date of the accident? _____
2. Approximately what time did the accident occur? _____:_____AM / PM
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What street were you on when the accident occurred? _____
6. What direction were you traveling in? _____
7. What city did the accident occur in? _____
8. What state did the accident occur in? _____
9. What type of impact was the auto accident? (Example: Rear ended, Passenger side impact, Driver side Impact)

_____

10. Did your vehicle hit anything after the accident (i.e. tree or guard rail)? If yes, please describe

_____

11. Were you the driver, front passenger, or rear passenger? _____
12. Did you know the accident was coming? ▫ No ▫ Yes If yes, were you braced for impact ▫ No ▫ Yes
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact you were:

    □Slowing down □Gaining Speed □Stopped □Moving at a steady speed

16. At the time of the impact, approximately how fast was your vehicle moving? _____MPH
17. At the time of the impact was the other car was:

    □Slowing down □Gaining Speed □Stopped □Moving at a steady speed

18. At the time of impact, approximately how fast was the other vehicle moving? _____MPH

Arnel Family Chiropractic

19. During and after the crash what happened to your vehicle? (Please circle all that apply)
    - ☐ Kept going straight
    - ☐ Kept going straight hitting a car in front
    - ☐ Was hit by another vehicle
    - ☐ Not Applicable
    - ☐ Spun around
    - ☐ Spun around and hit a stationary object
    - ☐ Hit a stationary object
20. Did you lose consciousness during the accident? No / Yes
21. How was your head positioned during the accident? _____
22. How was your torso positioned during the accident? _____
23. How were your hands positioned during the accident? _____
24. Did your head hit anything during the accident? No / Yes, please describe _____
25. Did your face hit anything during the accident? No / Yes, please describe _____
26. Did your shoulders hit anything during the accident? No / Yes, please describe _____
27. Did your neck hit anything during the accident? No / Yes, please describe _____
28. Did your chest hit anything during the accident? No / Yes, please describe _____
29. Did your hips hit anything during the accident? No / Yes, please describe _____
30. Did your knees hit anything during the accident? No / Yes, please describe _____
31. Did your feet hit anything during the accident? No / Yes, please describe _____
32. What kind of headrest was in your vehicle? ☐ Movable fixed headrest ☐ Non-movable fixed headrest ☐ No headrest
33. Where was the headrest positioned on your head? (Please circle which applies best)
    - ☐ At the top of the back of your head
    - ☐ At the middle height of the back of your head
    - ☐ At the lower portion of the back of your head
    - ☐ At level with the back of your neck
    - ☐ At the level of your shoulder blades
34. Did you have your seatbelt on during the accident? ☐Yes ☐No
35. Did you slide out of your seatbelt during the accident? ☐Yes ☐No ☐Partially
36. Choose the items that dented inward:
    - ☐ Floorboards ☐Side door ☐ Dashboard ☐ Not Applicable

233 Boston Post Road.
Orange, CT 06477
(203) 799-1234

Arnel Family Chiropractic

37. Choose the doors that would not open as a result of the accident:

☐ Front left ☐ Rear left ☐ front right ☐ Rear right ☐Not Applicable

38. What was damaged in your vehicle? (Please circle all that apply)

☐ Completely totaled	☐ Windshield	☐ Rear window	☐ Trunk
☐ Steering wheel	☐ Mirror	☐ Front left door	☐ Front right door
☐ Dashboard	☐ Knee bolster	☐ Rear bumper	☐ Front bumper
☐ Seat frame	☐ Back left door	☐ Side window	☐ Back right door

Other: _____

39. Did you go to the hospital/urgent care/doctor? If no, why and do not answer 40-48 _____

_____

40. How did you get to there? _____

41. What was the name of the facility/office? _____

42. Were you hospitalized overnight? _____

43. Circle what you were prescribed at the hospital (if applicable):

☐Pain Medication ☐Muscle Relaxers ☐Not Applicable

44. Did you receive any stitches for any cuts at the hospital? If yes, which area(s) of the body?

_____

45. Did you receive any of the following at the hospital?

☐Neck Brace ☐Back Brace ☐Not Applicable

46. Were x-rays taken at the hospital? If yes, which area(s) of the body were they taken?

_____

47. Was an MRI/CT Scan taken at the hospital? If yes, which area(s) of the body were they taken?

_____

48. Were there any other special imaging or testing done? If yes what imaging/testing was done and which area(s) of the body were they performed on?

_____

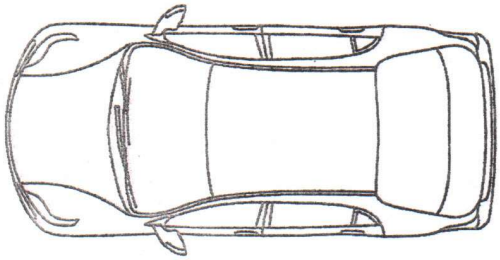
Patient Signature _____ Date: _____

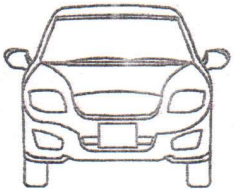
233 Boston Post Road.
Orange, CT 06477
(203) 799-1234
Cell (203) 668-2814

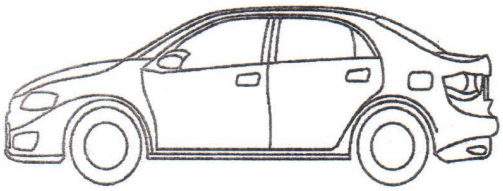
Arnel Family Chiropractic

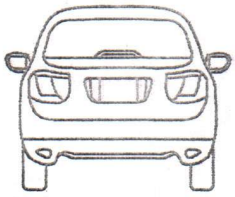
ACCIDENT HISTORY:

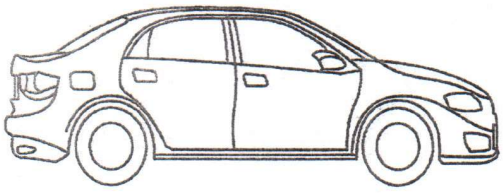
Date of Accident: _____ Time of Accident: _____ AM or PM











State how the accident happened in your own words:

_____

_____

_____

_____

_____

_____

_____

← Please indicate where your car was damaged to the best of your ability.

Patient Signature: _____ Date: _____ 1

233 Boston Post Road.
Orange, CT 06477
(203) 799-1234
Cell (203) 668-2814