



## 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 immediately 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Extra notes:

\_\_\_\_\_

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Name (signature): \_\_\_\_\_ Date: \_\_\_\_\_