SPINE STRENGTH FOR HEALTH CENTER, PLLC (LIFE CHIROPRACTIC)

COLLISION DESCRIPTIVE - Today's date: _____________

Name: ___________________________ Date of Injury: __________Claim #: ____________________

Name of Responsible Auto Insurance Company: ____

Address: _____________________________________ Tel: __________ Agent Name: _________________________

Date, Time, City and County in which Collision occurred: ____________________________

If a traffic violation was issued, to who was it issued? _______________________________

Did the police come to the collision site? Yes No

Was a police report filed? Yes No

Did you obtain the other parties contact, registration, and auto insurance details? Yes No

Were there any witnesses? Yes No If yes, who? ____

Make, model and year of the vehicle you were occupying? ____________________________

Your Position Within Your Vehicle Prior To And At The Moment Of The Collision

____Driver Passenger ____Middle Front ____Right Front ____Left Rear ____Middle Rear ____Right Rear

Name the thoroughfare on which you were situated: _______________________________________

Did the collision take place at: ____an intersection ____going uphill ____going downhill ___on a high-way

Specifically describe the moments leading up to the collision:

____

____

____

____

____

____

____

****Bring a copy of the collision report so that it can be attached to your clinical records.**

Printed Name: ____________________________ Date: ____________________

VEHICLE/ROAD/WEATHER CONDITIONS

Patient Vehicle Type

____Compact car ____Mid-size car ______Full-size car ____SUV ____Pickup truck ____Motorcycle

____Semi-trailer truck ____Utility truck ____Other____________________________

Second Vehicle Type

___Compact car ____Mid-size car ____Full-size car ____SUV ____Pickup truck ____Motorcycle

____Semi-trailer truck ____Utility truck ____Other_____________________________

ThirdVehicle Type

____Compact car ____Mid-size car ______Full-size car ____SUV ____Pickup truck ____Motorcycle

____Semi-trailer truck ____Utility truck ____Other____________________________

Road Driving Conditions

____Dry ____Wet ____Icy ____Snow-covered ____Muddy

Road Type

____Asphalt ____Concrete ____Gravel ____Dirt

Weather Conditions

____Clear ____Cloudy ____Dark ____Foggy ____Raining ____Snowing ____Windy

Printed Name: ____________________________ **Date:** ____________________

PRE-COLLISION DETAILS

Patient Vehicle

Was vehicle moving? ____Yes ____ No If yes, how fast? _____ Was vehicle braking? ____Yes ____ No

Second Vehicle

Was vehicle moving? ____Yes ____ No If yes, approx how fast? _____ Was vehicle braking? ____Yes ____ No

Third Vehicle

Was vehicle moving? ____Yes ____ No If yes, approx how fast? _____ Was vehicle braking? ____Yes ____ No

Aware/Seatbelt/Airbag/Headrest

Aware of the Impending Collision? ____Yes ____ No If yes, were you able to brace yourself? Yes No

Seatbelt: ____Yes ____No ____Lap belt only ____Lap/shoulder harness

Airbag: ____Yes ____No Airbag active: ____Yes ____No ____Front inflation ____Side inflation

Headrest: ____Yes ____No ____Up position ____Middle position ____Lower position

Was the back of your head contacting the headrest before the collision? This is an important question.
____Yes ____No

In relation to the base of your skull, where was the headrest? **a**bove below at base

Head Position

____Looking straight ahead ____Face forward looking up ____Face forward looking down

____Looking left head level ____Looking right head level

____Looking left upwards ____Looking right upwards

____Looking left downwards ____Looking right downwards

____Looking in the front rear view mirror ____Looking in the outside rear mirror ____Left ____Right

Printed Name: ____________________________ Date: ____________________

COLLISION DETAILS

First Impact

____Patient vehicle struck by other vehicle(s) ____Patient vehicle struck other vehicle(s)

First Impact Location

____Front ____Front Right ____Front Left ____Right ____Left ____Right Rear ____Left Rear ____Rear ____Top

Second Impact Location if Any

____Patient vehicle struck by other vehicle(s) ____Patient vehicle struck other vehicle(s)

____Front ____Front Right ____Front Left ____Right ____Left ____Right Rear ____Left Rear ____Rear ____Top

Results of Impact: Where Did Your Body Go and
Did Any Part of Your Body Strike Anything in the Vehicle?

Body was thrown: ____Forward ____Backward ____Right ____Left ____Can't remember

Head hit: ____Airbag ____Front windshield ____Rearview mirror ____Steering wheel ____Nothing

If Your Head Hit Anything, What Part of Your Head Hit?

____Forehead ____Back of Head ____Left Side of Head ____Right Side of Head

____ Top of Head ____ Cheeks ____Nose____ Chin ____Other ________________

____Dashboard ____Back of front seat ____Side window/door ____Headrest ____Another person

Chest hit: ____Airbag ____Front windshield ____ Rearview mirror____ Steering wheel ____Dashboard

____Back of front seat ____Side window/door____ Headrest ____Another person ____ Nothing

Shoulders hit: ____Shoulder harness ____Side window/door ____ Front of front seat

Back of front seat ____ Another person ____Nothing

Knee(s) hit: ____Center console ____Dashboard ____Back of front seat ____Door panel

____Another person ____Nothing

Hips hit: ____Steering wheel ____Dashboard ____Back of front seat ____Center console

____ Door Panel ____Another Person ____Nothing

Printed Name: ______________________________ Date: ______________________

What was the last thing you remember before the collision?

____

What is the very next thing you remember after the collision?

____

Did you receive any bleeding cuts? ____ YES ____ NO If YES, where were the cuts? _______________________

____

Did you receive any post-collision bruising? ____Yes ____ No If YES, any photographs? ____YES ____NO

If YES, where and how long did it/they last?

____

HEAD TRAUMA HISTORY

1. **____Yes ____No** Was there an altered state of mental awareness at the time of impact and/or shortly after impact? YES NO. If YES, describe: ____
   ____
2. **____Yes ____No** Have you lost any memory of events prior to your head injury? YES NO
3. **____Yes ____No** Has your memory been different since the head injury? YES NO
4. **____Yes ____No** Did you have a cut, lump or bruise on part of your head after the head injury? Where? ____
5. **____Yes ____No** Have you had any head injuries in your past? YES NO. If YES describe ________________
   ____
6. **____Yes ____No** Have you had any x-rays taken other than those taken at the hospital if any were taken there? YES NO. If YES, where and by whom? ______________________________________
7. **____Yes ____No** Have you had a computed tomography (CT) or magnetic resonance imaging (MRI) scan taken of your head? YES NO. If YES, name of facility ________________________________

Vehicle Damage

Patient Vehicle: ____Totaled ____Significant Damage ____Light Damage ____No Damage

Second Vehicle: ____Totaled ____Significant Damage ____Light Damage ____No Damage

Third Vehicle: ____Totaled ____Significant Damage ____Light Damage ____No Damage

Hospital

Went to hospital: ____Yes ____No

If Yes: ____Immediately ____Later in the same day ____Next day ____On ___________ (date)

Transported to hospital by: ____Private transportation ____Ambulance ____Life flight____ Other____

Printed Name: ____________________________ **Date:** ____________________

Hospital Recommendations

____No instructions ____Rest ____Give it some time to heal on its own

____Do some exercises ____Consult this clinic ____See a chiropractor ____See own doctor

____See orthopedist ____See neurologist ____See other ____________________________________

Given prescription medication? Yes No. If yes, what and what dose? ______________________________

Given over the counter medication? Yes No. If yes, what and what dose? ___________________________

Hospital procedures

X-rays taken: ____Yes ____No

Did You Stay Overnight in the Hospital? ____Yes ____No

Other Health Care Providers I Have Consulted or Am Consulting

In addition to or instead of attending a hospital, provide the name and address of any other health care providers you have consulted or are consulting regarding your injuries arising from this specific collision. of _____/_____/20_____

1.____

2.____

3.____

4.____

Is there any other information you perceive would help us to help you? ____Yes ____No

If yes, explain: ____

____

____

Print Name: _________________________ **Signature:** ___________________________

Parent/Guardian Signature for minor: _______________________________ **Date:** _____________