Accident Information

Patient Name _____Date _____

If your condition is accident, please complete the following questions?

Date of accident _____/_____/_____ Hour _____ Location _____

How did the accident occur ? On the job _____ Automobile collision _____

Other, please describe _____

Did you go to the hospital ? Yes _____No _____

Do you currently have an attorney advising you for this accident ? Yes _____No _____If yes, please provide

Their name _____ City _____ Zip code _____

Telephone number _____

- **If on the job**, did you report the injury to your supervisor? Yes _____No _____
  If yes, when _____

If on the job, please describe _____

_____

- **If an automobile collision,** where you ? Driver _____ Passenger _____ Which seat ? _____

Impact direction? Front _____ Rear _____ Side _____
Driver's side _____ Passenger's side _____ Not sure _____

Safety restraints? No_____ Yes, lap only_____ Yes, shoulder only_____
Yes, lap and shoulder_____ Not sure _____

Was there a headrest on your seat? Yes_____ No_____ Did you lose consciousness? Yes _____ No_____ Unsure _____

Did you hit your head ? Yes _____ No _____ Did you break any bones? Yes _____ No _____ Unknown _____

Was you vehicle driveable? Yes _____ No _____ (end of auto related questions)

Please describe any important facts not already asked _____

_____

_____

Patient signature _____Date _____/_____/_____

Ashby Chiropractic Clinic 1475 Richardson Drive, Suite 204 Richardson, TX 75080 **972-414-8181**