



# SALAMA CHIROPRACTIC CENTER

George Salama, D.C. • Michele Kin, D.C. • Jimmy Burleson, D.C. • Edward Boudreau, D.C. • Emilio Zeolla, D.C.

## Automobile Accident Information

1. What was the date of the accident? \_\_\_\_\_
2. What time did the accident occur? \_\_\_\_\_
3. How many vehicles were involved in the accident? \_\_\_\_\_
4. What was the estimated damage to the vehicle you were in? (in dollars) \_\_\_\_\_
5. What city did the accident occur in? \_\_\_\_\_
6. What state did the accident occur in? \_\_\_\_\_
7. What type of impact was the auto accident?  
 rear ended       hit on drivers side       hit another vehicle form behind       hit on passenger side
8. Did your vehicle hit anything after the accident? if yes, please describe \_\_\_\_\_
9. Where were you sitting in the vehicle during the accident?  
 driver       rear left passenger       front passenger       rear right passenger
10. Did you know the accident was coming?  
 unaware of impending collision       aware of impending collision       aware of impending collision and I braked
11. What type of vehicle were you in?  
 compact car       mid size car       full size car       truck  
 SUV       minivan       van       other
12. What type of vehicle impacted yours?  
 compact car       mid size car       full size car       truck  
 SUV       minivan       van       other
13. At the time of the impact, how fast was your vehicle moving?  
 slowing down       stopped       gaining speed       moving steady speed
14. Did you lose consciousness during the accident?  yes       no
15. Did you have your seatbelt on during the accident?  yes       no
16. Did you go to the hospital?  yes       no      If no, why and skip 38-43 \_\_\_\_\_
17. How did get to the hospital?  
 ambulance       police car       walked       helicopter       drove self       other
18. What was the name of the hospital? \_\_\_\_\_
19. Were you hospitalized over night?  yes       no
20. Check what you were prescribed at the hospital  
 pain medication       muscle relaxors       neck brace
21. Did you receive any stitches for any cuts at the hospital?  yes       no
22. Were x rays taken at the hospital? If yes, which area was taken?  
 neck       skull       mid back       lower back       pelvis       hips  
 leg       knee       foot       shoulder       arm       other

Patient Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_