Fogarty
Chiropractic Life Clinic

LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

Automobile Accident History Form

Your Name: _____ Today's Date_____

Date of Accident:_____ Time of Accident: _____ A.M. / P.M.

Street of Accident_____ Heading N / S / E / W

City of Accident:_____

Road Conditions at time of accident: WET / DRY/ ICY/ OTHER_____

List the year, make and model of the car you were in:
Year:_____Make:_____Model:_____
Was the vehicle you were in stopped at the time of the impact? YES / NO
If yes, was the driver's foot on the brake? YES / NO
If no, then estimate the speed of the vehicle you were in: _____mph

List the year, make and model of the other vehicle:
Year:_____ Make: _____ Model:_____

Was the other vehicle moving at the time of the collision? YES / NO
If yes, what was the approximate speed?_____mph

If the other vehicle was moving at the time of the collision, was it:

SLOWING DOWN

SPEEDING UP

TRAVELING AT A STEADY RATE OF SPEED

Which of the following vehicle parts were broken during the accident? _____

_____

What was the estimated cost damage to the vehicle you were in? $ _____

Please describe, to the best of your knowledge what happened during the accident:

_____

_____

_____

_____

_____

_____

_____

(please turn over)

Where were you seated in the vehicle?_____

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Were you aware of the impending collision prior to the impact, or did the impact surprise you? AWARE / SURPRISED

Was the trunk of your body pointed straight forward? YES/ NO
If no, in what direction was it turned?_____

Was your head pointed straight forward? YES / NO
If no, in what direction was it turned?_____

How far is the top of the headrest or seatback from the top of your head (approximately): _____ inches ABOVE / BELOW.

Were you wearing a seatbelt? YES / NO
If yes, was it a LAPBELT ONLY or SHOULDER AND LAPBELT?
Did the police come to the accident scene? YES / NO; Is there a report? YES / NO
Did you go to the hospital? YES / NO, If yes:
What is the name of the hospital?_____
How did you get there?_____
What parts of your body were X-rayed?_____
What did the hospital do for your injuries?_____
How long did you stay at the hospital?_____
Were there any bleeding cuts sustained in the accident?_____
Were there any bruises sustained in the accident?_____
Did you receive any injury or bruising from your seatbelt? YES / NO
Did you lose consciousness (blackout) upon impact?_____
Did you experience a flash of light or explosion in your head? YES / NO
On what part of the vehicle did your body parts hit?_____

WINDSHIELD FRONTSEAT RIGHT/LEFT SIDE WINDOW
STEERINGWHEEL OTHER_____

Did you become?

CONFUSED DISORIENTED LIGHTHEADED
DIZZY NAUSEATED BLURRED VISION
RINGING/BUZZING IN THE EARS

Immediately following the accident, if you still have any of these symptoms which are they?_____

Are you currently suffering from any of the following ?

RESTLESSNESS, DIFFICULTY CONCENTRATING, SLEEPLESSNESS, IRRITABILITY, DIFFICULTY WITH MEMORY, FORGETFULNESSS , REDUCED TOLERANCE TO COLD, REDUCED TOLERANCE TO HEAT OR REDUCED TOLERANCE TO ALCOHOL.

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