

Quality of Life Chiropractic

Jamie Marshall, D.C.
6910 FM 1488 Suite 3
Magnolia, TX 77354
281-789-4182

Patients Name: _____

Today's Date: _____

Accident Information

Date of Accident: _____

Time of Accident: _____

Name of the location/street on which you were traveling: _____

Where you the: Driver Front Passenger Rear Passenger

Make & Model of the vehicle you were occupying: _____

Was this vehicle equipped with airbags Yes No Did the airbags inflate? Yes No

Where you wearing your seatbelt? Yes No

Did the impact to your vehicle come from the: Front Rear Right Side Left Side Other

In relation to the base of you skull, where was the headrest? Above Below At the base

In which direction were you headed? North South East West

During Impact, were you facing? Forward Right Left

Did any part of your body strike anything in the vehicle Yes No (Ex: head, shoulders, neck, low back, midback, wrist/hand, foot/ankle, knee)

If yes explain: _____

Did the accident render you unconscious? Yes No If yes, for how long? _____

What was the approximate speed of your vehicle? _____mph Speed of the OTHER vehicle? _____mph

Were you Aware OR Surprised by the impact? What did your vehicle impact? A Vehicle Other _____

Number of people in the accident? _____

Names of passengers: _____

- Are the passengers seeking chiropractic care for their injuries? Yes No
- Do they have personal injury protection insurance or Attorney helping with their care? Auto Insurance Attorney

In your own words describe the accident: (Ex: weather, visibility, time of day, witness, road conditions, vehicles involved, etc.)

Please describe how you felt immediately after the accident: (Ex: scared, frustrated, angry, nervous, confused, indifferent, etc.)

Legal Information

Did the police come to the accident scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was a Police report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was a traffic violation issued? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To whom: _____	
Have you retained an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, whom? _____	
Attorney Phone Number: _____	

Medical Information

Have you gone to a hospital or seen any other Doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When did you go? <input type="checkbox"/> Immediately <input type="checkbox"/> Next Day <input type="checkbox"/> 2 Days Plus	
How did you get there? <input type="checkbox"/> Ambulance <input type="checkbox"/> Private transportation	Was Medicine prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the hospital and/or attending doctor: _____	
Was he/she a: <input type="checkbox"/> D.D.S <input type="checkbox"/> M.D. <input type="checkbox"/> D.C. <input type="checkbox"/> D.O.	Were X-ray's taken? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been able to work since the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you restricted as a result of this injury <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Symptoms: Please Circle the Body Parts That Are Involved In the Injury

