DAMATO CHIROPRACTIC CENTER
OF GLASTONBURY

AUTO ACCIDENT

Name_____Sex_____DOB_____

Address_____
Street City St Zip

Date and time of accident?_____

Road conditions and visability?_____

Name of Auto Insurance Company:_____Policy#_____

Year/Make/Model of car you occupied:_____

Position in car/description:_____

Was the vehicle: □ Moving □ Stopped □ Rolling □ Accelerating □ Decelerating Seat Belts? □Yes □No

Year/Make/Model of other car(s) involved:_____

Direction Traveling: □ North □ East □ South □ West

Police Respond:□Yes □No Was a police report filed? □Yes □No EMT's respond? □Yes □No

Were any tickets issued? □Yes □No If yes, to whom:_____

Where were you taken after the accident?_____

What are of the car was impacted?_____

Did you anticipate the collision? □Yes □No Did you brace for impact? □Yes □No

Where were your hands positioned?_____

Which direction was your head facing? □ Forward □ To the right □ To the left □ Behind □ Up □ Down

Did the airbags deploy? □ Yes □ No Were objects thrown in the car?_____

Were any of your body parts struck in the collision?_____

If so, what part of the car did your body strike?_____

Where did you feel pain?_____

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730 Hebron Avenue, Suite 4, Glastonbury, CT 06033
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What are your current symptoms?_____

How did you feel immediately following the Collison? □ Stunned □ Disoriented □ Lost consciousness

□ Felt tightness □ Discomfort □ Pain □ Frightened □ Popping/ripping sensation

Type of pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting □Burning □Tingling

□Cramps □Stiffness □Swelling Other_____

Is pain: □Occasional? □Intermittent? □Constant? Rate severity of pain from 0 to 10_____

Does it interfere with your: □Work □ Sleep □ Daily □ Routine □Recreation

Activities/movements that are painful to perform:_____

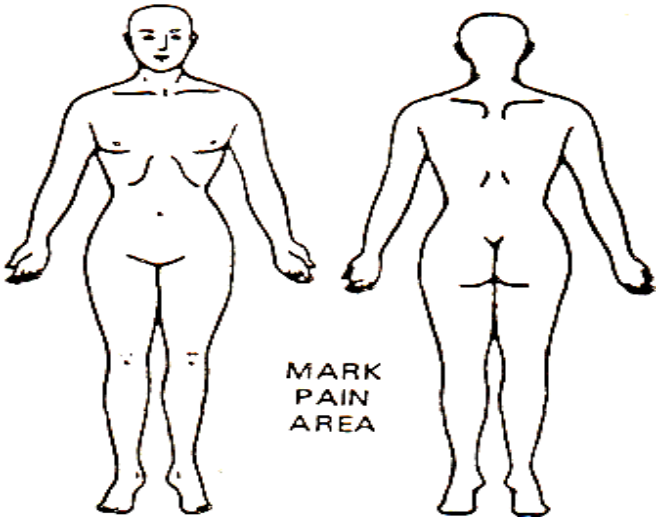
_____

What helps pain?_____

Name of any other doctor consulted since your accident_____

Treatment received?_____

Please indicate on the picture where you feel pain/discomfort:



Patient Signature:_____Date:_____

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