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## Auto Accident

What was the date of the accident? \_\_\_\_\_

What time did the accident occur? \_\_\_\_\_

How many vehicles were involved in the accident? \_\_\_\_\_

What was the estimated damage to the vehicle you were in? \_\_\_\_\_

What state did the accident occur in? \_\_\_\_\_

What city did the accident occur in? \_\_\_\_\_

What street or intersection were you on when the accident occurred? \_\_\_\_\_

What direction were you traveling in? \_\_\_\_\_

What type of impact was the auto accident? \_\_\_\_\_

Did your vehicle hit anything after the accident? If yes, please describe: \_\_\_\_\_

Where were you sitting in the vehicle during the accident? \_\_\_\_\_

Did you know the accident was coming? \_\_\_\_\_

What type of vehicle were you in? \_\_\_\_\_

What type of vehicle impacted yours? \_\_\_\_\_

At the time of impact, how fast was your vehicle moving? \_\_\_\_\_

At the time of impact, how fast was the other vehicle moving? \_\_\_\_\_

During and after the crash, what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle

- spun around
- spun around and hit a stationary object
- hit a stationary object

Did you lose consciousness during the accident?                      Yes      No

How was your head positioned during the accident? \_\_\_\_\_

How was your torso positioned during the accident? \_\_\_\_\_

How were your hands positioned during the accident? \_\_\_\_\_

Did your head hit anything during the accident? No Yes, please describe\_\_\_\_\_

Did your face hit anything during the accident? No Yes, please describe\_\_\_\_\_

Did your shoulders hit anything during the accident? No Yes, please describe\_\_\_\_\_

Did your neck hit anything during the accident? No Yes, please describe\_\_\_\_\_

Did your chest hit anything during the accident? No Yes, please describe\_\_\_\_\_

Did your hips hit anything during the accident? No Yes, please describe\_\_\_\_\_

Did your knees hit anything during the accident? No Yes, please describe\_\_\_\_\_

Did your feet hit anything during the accident? No Yes, please describe\_\_\_\_\_

What kind of headrest was in your vehicle?

- movable fixed headrest
- unmovable fixed headrest
- no headrest

Where was the headrest positioned on your head?\_\_\_\_\_

Did you have your seatbelt on during the accident?\_\_\_\_\_

Did you slide out of your seatbelt during the accident?\_\_\_\_\_

What was damaged in your vehicle? (circle all that apply)

- windshield
  - steering wheel
  - dashboard
  - seat frame
  - side window
  - rear window
- rear bumper
  - front bumper
  - trunk
  - front left door
  - front right door
  - back left door
- mirror
  - knee bolster
  - back right door
  - completely totaled

Choose the items that dented inward:

- floorboards
- side door
- dashboard

Choose the doors that would not open because of the accident:

- front left
  - rear left
- front right
  - rear right

Did you go to the hospital? If not, why? (do not answer questions 38-43)\_\_\_\_\_

How did get to the hospital?\_\_\_\_\_

What was the name of the hospital?\_\_\_\_\_

Were you hospitalized overnight?\_\_\_\_\_

Circle what you were prescribed at the hospital:

- pain medication
- muscle relaxers
- neck brace

Did you receive any stitches for any cuts at the hospital?\_\_\_\_\_

Were x-rays taken at the hospital? Yes No

If yes, which area was taken?\_\_\_\_\_

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

\_\_\_\_\_  
Date