



THE CONDE CENTER

For Chiropractic Neurology

Motor Vehicle Accident Health History Form

Date of the accident: _____

Your Vehicle

What is the make & model of your car/truck? _____

What is the year? _____

What was your position in the vehicle? (i.e. Passenger, Driver, Backseat..etc)

At the time of the accident, what kind of surface were you driving on?

Were you restrained by a seatbelt? If yes, what kind? _____

Did your seat have a headrest? _____

Where was the tip of the headrest positioned in relation to the top of your head?

Do you recall how far your headrest was from the back of your head? If yes, please explain _____

The Other Vehicle(s)

How many vehicles struck your car/truck? _____

What is the make & model of their car/truck? _____

What is the year? _____

The Accident

Approximately how fast were you going at the time of the impact?

_____ (mph)

Approximately how fast was the other car going at the time of impact?

_____ (mph)

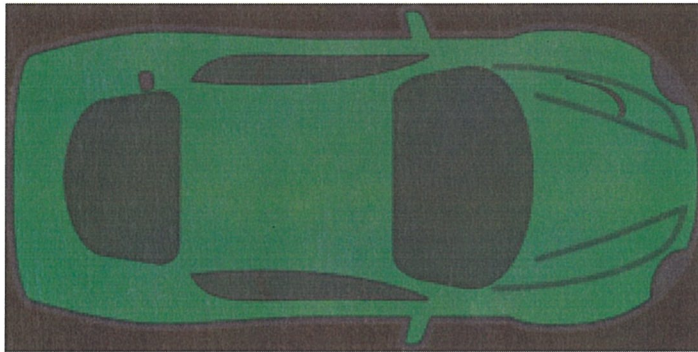
About how far did your car move after being struck?

_____ (feet)

If your car was standing still at the point of impact, where was your foot or feet?

Where was your head facing when the collision occurred?

On the diagram below, please mark the point(s) of impact on to your vehicle.



Which direction did the striking vehicle come from? _____

After the accident did you strike anything else? _____

Was there any damage done to your vehicle? _____

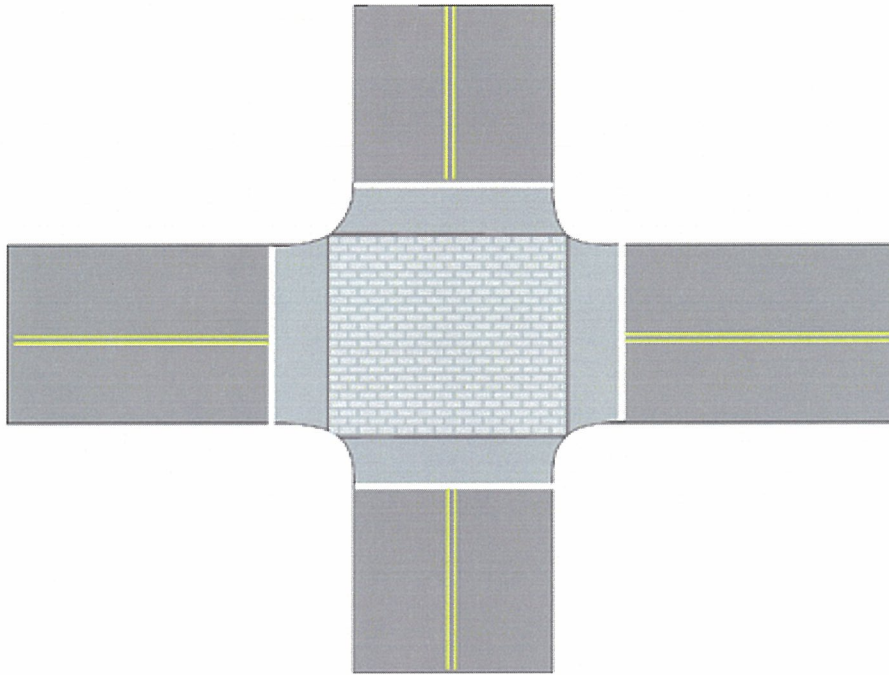
Was there any damage done to the other vehicle? _____

Did your airbags deploy? _____

Did the police arrive? _____

The Accident, in your words:

Below please describe in your words how the accident occurred, use the diagram of an intersection if helpful:



Injuries:

Were you aware of the collision as it occurred? _____

If yes, then did you brace your arms and legs? _____

Did you lose consciousness at any point during or after the collision? _____

Were you ejected from the vehicle? _____

Did any part of your body strike the interior of your vehicle? _____

If yes, please explain:

Did you sustain any injuries occur outside of your vehicle? _____

If yes, please explain:

Did you suffer any bruises, cuts, or broken bones from the collision? _____

If yes, please explain:

Did you suffer any of the following symptoms (circle all that apply) :

Dizziness.

Light Headedness.

Severe Headaches.

Vertigo.

Blurry Vision.

Confusion.

Memory Loss.

Extreme Drowsiness.

Difficulty with focus or concentration.

Sensitivity to light.

Visual disturbances.

Nausea.

Vomiting.

Muscle weakness.

Numbness.

Ringing in ears.

Difficulty in speech.

Depression.

Crying for no reason.

Anxiety.

Medical History

Did you go to the hospital after the accident? _____

If yes, please answer the following five questions:

1. What was your use of transportation? _____
2. How long after the accident did you arrive at the hospital? _____
3. What was your use of transportation when you left the hospital?

4. Were x-rays or other imaging procedures performed? _____
5. Did you receive treatment or any prescription/medications at the hospital? _____

If yes, please explain :

Have you ever been involved in a motor vehicle accident before? _____

If yes, please answer the four questions below:

1. When & where did the accident(s) occur?

2. Who did you see for care?

3. What type of care did you receive?

4. Did all of your symptoms resolve from the above mentioned accidents?

Impact on Your Life :

Please mark the activities below that have been adversely affected, or are difficult to perform, since your motor vehicle accident.