Landen Chiropractic, P.C.
139 West Third Street, Suite A
Chadron, NE 69337
308-432-8098

Auto Accident History

Date: ______________________________

Name: ____ Age________ Sex _________

Address: ____

City: ___________________________State:_______________________________ Zip: _____________

Driver's License #: __________________________Phone:___________________________________

GENERAL SYMPTOMS:

Current Symptoms: ____

____

Were they immediate or delayed? ____

Did you hit any part of your body during the collision, for example, head on dash or chest on steering wheel? ________________ How? ____

Where were you taken after the accident? ____

Were you hospitalized? ________ If yes, where and for how long? __________________________

Did you receive care from any other health care specialists? ________________________________

If yes, what is the specialist's name? ____

What type of care were you given and for how long? _______________________________________

Have you ever been injured in a similar manner? ________ If yes, how and when? _____________

____

ACCIDENT HISTORY:

Date and time of accident: ____

In your own words, how did the accident happen? ____

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Were you driving? _________ Was it your car? __________ If not, whose? ____________________

Passenger(s)? Front __________ Back _________ Right Side___________ Left Side ___________

Were you rotated in the seat? _____________________

Other people in the car:
Name and Address: ____

Name and Address: ____

Name and Address: ____

Seat belts on? _______ Shoulder harness on? _______ Were you tired? _______ Awake? ______

Conditions at time of accident: (light/dark; dry/wet, etc.) _____________________________________

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What were the traffic conditions? ____

What was the posted speed limit? ___________ How fast were you going? ___________________

Type of road: Two Lane ______ Four Lane ______ Gravel ______ Tar ______

Did it happen at a stop sign? ______ Traffic light? ______ Intersection? ______

Was your car hit? Front ______ Back ______ Left side ______ Right side ______

What damage was done to your car? ____

Did you strike another car? ______ Front ______ Back ______ Side ______

Damage to other car? ____

What type of vehicle were you driving? Make _____________________________ Year __________

What type of vehicle was involved in the accident? ______________________________________

Accident report by police? _______ City _____________________ County ___________ State ____

Any tickets issued? ______ If yes, for what? ____

Did your vehicle go off the road? ______ If yes, into where or what? __________________________

Were you unconscious at any time after the accident? _____________________________________

Do you remember impact? ____

Have you missed any time at work? _____________ How long? _____________________________

Please draw the accident on the back of this sheet. Indicate directions and cars involved.