Schubbe Resch Chiropractic & PT Center - Appleton 920-738-0220

Personal Injury Report/Auto Accident Form

Name: ______________________________________ **Occupation:** _________________________ **Date:** __________________

Date of Accident: _____________ **Time of Accident:** _______ AM/PM Aware of Impending Collision? ___ Yes ___ No

Were you ____ Driver or ____ Passenger in the car? Was your car ____ Stopped or ____ Moving? Est. Speed _______

Road condition (s) ____ Dry ____ Damp ____ Wet ____ Rain ____ Ice ___ Snow ____ Other ____________________

Head Rest: ____ None ____ Molded ____ Adjustable **Head Position:** Facing ____ Forward ____ Left ____ Right

Seat Belt: ____ Wearing with Harness ____ Wearing without Harness ____ Not Wearing a Seat Belt

Hands: ____ 1 on wheel ____ 2 on wheel **Wearing Glasses:** ___ Yes, ___ No / Still on after Collision? ___ Yes, ___ No

Felt body go: ___ Forward ___ Backward ___ Sideways ___ Other ____

Was there a second collision in the vehicle? ___ Yes ___ No / If Yes, Explain ______________________________________

Was there a second collision outside of vehicle? ___ Yes ___ No / If Yes, Explain ___________________________________

Other(s) in the car? (D = driver P = passenger) ____

Did you lose consciousness? ___ Yes ___ No Initial signs and symptoms: ___ None ___ Headache ___ Dizziness

___ Disorientated ___ Shock ___ Numbness/Tingling in; ___ arms ___legs ___ Other __________________________

___ Neck pain/stiffness ___ Upper back pain/stiffness ___ Middle back pain/stiffness ___ Low back pain/stiffness

Onset of symptoms: Date: __________________ Day of week: _______________ Hours after the accident: __________

After accident I went: ___ Home ___ Hospital, / **When**? ___ Right away ___ Later / **By**: ___ Ambulance ___ Car

Hospital Procedures: ___ X-rays ___ Lab Tests ___ Cervical Collar ___ Prescription(s)___________________________

Diagnosis given: ______________________________ Instructions: ____

I went to my doctor's office: Dr. Name: ___________________________ Date: ____________ Time: __________AM/PM

Police Involved? ___ Yes ___ No **Report Filed?** ___ Yes ___ No **Were brakes applied?** ___ Yes ___ No

Car: Year ________ Make ______________ Model _________________ / ___ Manual ___ Automatic

Other Car(s): Year ________ Make ______________ Model _______________

Location of impact on your vehicle? ___ Front ___ Back ___ Right Side ___ Left Side

Estimated Property Damage: $__________ ___ Vehicle is Drivable ___ Vehicle is not Drivable

PRIOR Medical care and doctor: ____ € X-rays Date: _____________

PRIOR Chiropractic care and doctor: ____ € X-rays Date: _____________

PREVIOUS Auto injuries:____ Date: ____________________

PREVIOUS Workers Compensation Injuries: ______________________________________ Date: ____________________

PREVIOUS Sports Injuries: ____ Date: ____________________

Draw accident scene