HEALING WAY CHIROPRACTIC
13110 S.E. Sunnyside Road, Suite B
Clackamas, OR. 97015
(503) 698-5866 (FAX) 698-5787
Dustin Hundley, DC

Q&A

NAME: _____ DATE: _____

Date of Accident: _____Time of Accident: _____ AM / PM

Location of Accident: _____

Road conditions of the time of the accident

□ Wet □ Dry □ Icy □ Other _____

Did the police come to the accident scene? Yes □ No □

Is there a report? No □ Yes □ With which Police Dept. _____

Did you go to the hospital? Yes □ No □

If yes, what hospital? _____

What city? _____

Were you x-rayed? Yes □ No □ What part (s) of your body?

_____

How long did you stay at the hospital? _____

Were medications prescribed? _____

Location of bruises, cuts, and abrasions: _____

Your Vehicle:

Year: _____ Make: _____ Model: _____

Other Vehicle(s):

Year: _____ Make: _____ Model: _____

Year: _____ Make: _____ Model: _____

Other:

_____

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Where were you seated in the vehicle?

Driver □ Passenger □ Front Seat □ Back Seat Right □ Left □

Were there other people in your vehicle? Yes □ No □ Who? _____

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? Aware □ Surprised □

If your vehicle was moving at the time of impact, was it:

Slowing down? Yes □ No □

Gaining speed? Yes □ No □

Traveling at a steady rate of speed? Yes □ No □

Approximately, how fast was your vehicle moving? _____ Unknown □

Was your car stopped at the time of impact? Yes □ No □

If yes, was the driver's foot also on the brake? Yes □ No □

Unknown □

Was the other vehicle moving at the time of the collision? Yes □ No □

If yes, what was the approximate speed? _____ mph

Unknown □

If the other vehicle was moving at the time of the collision, was it:

Slowing down □ Gaining speed □ Traveling at a steady speed □

What direction was your vehicle traveling? N □ W □ S □ E □

What direction was the other vehicle traveling? N □ W □ S □ E □

Which of the following car parts broke during the accident?

□ Windshield □ Front seat back

□ Right/Left side window □ Steering Wheel

□ Nothing broke □ Other _____

What is the estimated cost of damage to the vehicle you were in? $_____

Unknown □

Were you wearing a seat belt? Yes □ No □

If yes, was it a Lap seat belt □ Shoulder-lap seat belt □

Did you receive any injury or bruise from the seat belt? Yes □ No □

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If yes, please describe:

_____

_____

Did your seat have a Head Rest? Yes □ No □

Was it adjusted properly? Yes □ No □

Is your vehicle equipped with air bags? Yes □ No □

Did they inflate? Yes □ No □

On what part of the automobile did your following parts hit?

Head hit _____ Chest hit _____

Right/left shoulder hit _____ Right/left arm hit _____

Right/left hip hit _____ Right/left leg hit_____

Right/left knee hit _____ Other_____

Nothing hit the inside of the vehicle □

What was the first thing you remember following the accident?

_____

_____

Was your head facing straight forward? Yes □ No □

If no, what direction was it turned and by how much? (*very important*) _____

Did you experience a flash of light or explosion in your head? Yes □ No □

Did you lose consciousness (black out) upon impact? Yes □ No □

How Long? _____

Did you become: □ Confused □ Disoriented □ Ring/Buzz in ears

□ Light Headed □ Nauseated □ None of the above

□ Dizzy □ Blurred Vision from the accident?

Other: _____

If you still have any of those symptoms, which ones? _____

_____

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Are you currently suffering from any of the following:

- □ Headaches
- □ Neck Pain
- □ Neck Strain
- □ Sleeping Problems
- □ Numbness in Fingers
- □ Numbness in Toes
- □ Lights Bother Eyes
- □ Face Flushed
- □ Fainting
- □ Diarrhea
- □ Stomach Upset
- □ Fever
- □ Other:
- □ Low Back Pain
- □ Upper Back Pain
- □ Tension
- □ Chest Pain
- □ Head Seems Too Heavy
- □ Shortness of Breath
- □ Fatigue
- □ Loss of Memory
- □ Buzzing in Ears
- □ Feet Cold
- □ Constipation
- □ Nervousness
- □ Irritability
- □ Dizziness
- □ Ache in Arms
- □ Ache in Legs
- □ Depression
- □ Hearing
- □ Loss of Balance
- □ Loss of Taste
- □ Hands Cold
- □ Cold Sweats

_____

Please describe, to the best of your knowledge, what happened during this accident:

(You may also draw the accident if you think it will help)

_____

_____

_____

_____

_____

_____

_____

_____

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