Keefer CHIROPRACTIC Trusted Care

521 Yopp Rd. Ste 107, Jacksonville, NC 28540
910-333-9723

Patient Name: _____ Date:_____

Date of the accident:_____Time of the accident :_____ AM or PM

Describe in your own words, what happened in the accident:_____

_____

Where did the accident take place? (road, intersection, etc.) _____

What direction were you traveling in at the time of accident?_____ What direction was the other car traveling?_____

What state did the accident happen in? _____ What city did the accident happen in? _____

How many cars were involved in the accident? _____ What was the estimated damage to the car you were in? $_____

Where did the impact take place on the car? Front ____ Rear ___ Driver's Side ___ Passenger's Side ___ Other_____

What was the size of the car you were in? sub compact____compact_____mid-size_____ full size_____

What was the size of the other car? sub compact____ compact_____ mid-size_____ full size_____

What type of car were you in?_____ What type of car was the other car?_____

What was the visibility at the time of the accident? Clear____ sunny_____ dawn_____ dusk_____ night/dark_____ other_____

What were the road conditions? Dry____ Wet_____ Damp____ Snow_____ Icy_____ Clear_____ Other_____

Where were you sitting in the car? _____ Did you know that the accident was coming? No_____ Yes_____

Where you wearing a seatbelt? Lap belt: Yes_____ No_____ Shoulder Strap: Yes_____ No_____

Where you ejected from the car? Yes_____ No_____

Did you have a headrest? Yes____ No_____ Where was it positioned on your head?_____

Did the airbags deploy? Yes_____ No_____ Did you lose consciousness? Yes_____ No _____

Did your body hit anything in the car? No____ Yes(explain)_____

What body parts were injured? _____

Are there any or were there any cuts, bruising or bleeding after the accident on your body? No_____ Yes (explain) _____

_____

Patient's Signature: _____Date: _____

Doctor's Signature: _____

Patient Name: _____ Date:_____

Medical Treatment

Hospital/ER Treatment

Did you go to the hospital? No_____ Yes (where) _____ Date Treated at Hospital_____

Were you taken by ambulance? Yes_____ No (How did you get there?)_____

Was an examination performed on you? Yes _____ No _____

What Treatment was rendered at the hospital (medication, braces, etc.)? _____

Was there any imaging done (CT, MRI, X-rays, Etc.) ? No_____ Yes (explain) _____

Did this treatment help? No_____ Yes (explain) _____

Other Treatments

Have you seen any other doctor in relation to this accident outside of the ER? No____ Yes (Who/Where?) _____

If yes, when was this medical treatment received? _____

Were any imaging studies taken (x-rays, CT scans, MRI, etc.)? No_____ Yes (explain) _____ _____

What type of treatment did you receive (medication, collars, braces, etc.)? _____

Did the treatment received help your conditions? No_____ Yes(explain)_____ _____

By signing below, I verify that all of the information provided above is true to the best of my knowledge. I, understand that by signing below I take full responsibility for the information provided in relation to the auto accident in which I was involved in. I also understand that ultimately I am responsible for any charges for the treatments rendered in relation to this accident.

Patient Name:_____ Patient Signature: _____ Date:_____

Witness: _____ Witness Signature: _____ Date: _____

Doctor's Signature:_____ Date: _____