



Performance Chiropractic 9140 West 100<sup>th</sup> Ave Ste A5 Westminster CO 80021 (303) 425-4444  
Fax: (303) 425-4408 www.DrJustinTrosclair.com Dr. Justin Trosclair, D.C., C.K.T.P.

## Auto Accident Form

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please mark your involvement in the Auto Accident:  Pedestrian  Driver  Passenger

What are your current symptoms?  Pain  Numbness  Stiffness  Weakness

Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient was located:  Driver  Passenger- middle front  Passenger- right front  
 Passenger- left rear  Passenger- middle rear  Passenger -right rear

Patient Vehicle Type:  Compact  Mid-size  Full-Size  SUV  Pick-up  Motorcycle

Second Vehicle Type:  Compact  Mid-size  Full-Size  SUV  Pick-up  Motorcycle

Third Vehicle Type:  Compact  Mid-size  Full-Size  SUV  Pick-up  Motorcycle

Road Conditions:  Clear  Dark  Dry  Foggy  Icy  Wet

Road Type:  Asphalt  Concrete  Dirt  Gravel

Were you aware the accident was going to occur?  Yes  No

Were you wearing a seatbelt?  Yes  No

Did your airbag deploy?  Yes  No

Does your car have a head rest?  Yes  No

What position was the head rest in?  Up  Middle  Down

Patient's Head Position:  Looking Straight Ahead  Left Level  Left Up  Left Down  
 Right Level  Right Up  Right Down  Looking Up  Looking Down

### Accident Details

Was your car braking?  Yes  No Was your car moving?  Yes  No  
If yes, how fast? (mph)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70

Was the second vehicle braking?  Yes  No Was the second vehicle moving?  Yes  No  
If yes, how fast? (mph)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70

Was the third vehicle braking?  Yes  No Was the third vehicle moving?  Yes  No  
If yes, how fast? (mph)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70

### Collision Details

First Impact:  hit by other vehicle  hit other vehicle  hit by object  hit object



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**Impact Location:**  front  front-right  front-left  left  
 right  right-rear  left-rear  rear  top

**Second Impact:**  hit by other vehicle  hit other vehicle  hit by object  hit object  
**Impact Location:**  front  front-right  front-left  left  
 right  right-rear  left-rear  rear  top

**Collision Results**

**Body was thrown:**  Forward  Backward  Left  Right  Can't Remember

**Head Hit:**  airbag  front windshield  rearview mirror  steering wheel  
 dashboard  back of the front seat  side window/door  another person's body  headrest

**Chest Hit:**  airbag  steering wheel  dashboard  back of the front seat  
 side window/door  another person's body

**Shoulders Hit:**  shoulder harness  side window/door  back of front seat  another person's body

**Knees Hit:**  steering wheel  dashboard  back of the front seat  
 door panel  center console  another person's body

**Hips Hit:**  steering wheel  dashboard  back of the front seat  
 door panel  center console  another person's body

**Vehicle Damage**

**Patient Vehicle:**  totaled  significant damage  light damage  no damage  
**Second Vehicle:**  totaled  significant damage  light damage  no damage  
**Third Vehicle:**  totaled  significant damage  light damage  no damage

**Hospitalized**

Were you hospitalized?  Yes  No. If yes, please answer the questions below.

When were you hospitalized?  immediately  later same day  next day  date \_\_\_\_\_

How were you transported to the hospital?  ambulance  life flight  private transportation

**What did the hospital recommend?**  no instructions  see this clinic  see DC  
 see own doctor  see orthopedist  see neurologist  prescription medication  
 other: \_\_\_\_\_

**Did you have any xrays taken?**  Yes  No  
If yes, what areas? \_\_\_\_\_