



Performance Chiropractic 9140 West 100th Ave Ste A5 Westminster CO 80021 (303) 425-4444
Fax: (303) 425-4408 www.WestminsterChiropracticClinic.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? _____