Premier Therapy Center

Doctor: Stephen Badolato, MD Chiropractor: Brad A. Nelson, DC

Name:_____ Date of Birth:_____

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident?_____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? (ie. Rear-ended, T-boned) _____
10. Did your vehicle hit anything after the accident? If yes, please describe

_____

11. Where were you sitting in the vehicle during the accident?(ie. driver, rear, passenger) _____
12. Did you know the accident was coming?_____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours?_____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? - yes - no
19. How was your head positioned during the accident? (ie. Straight, forward, turned) _____
20. How was your torso positioned during the accident? (ie. Straight, forward, turned) _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? -no - yes, please describe_____
23. Did your face hit anything during the accident? -no - yes, please describe_____
24. Did your shoulders hit anything during the accident? -no - yes, please describe _____
25. Did your neck hit anything during the accident? –no - yes, please describe _____
26. Did your chest hit anything during the accident? -no - yes, please describe _____

(Turn Over)

27. Did your hips hit anything during the accident? –no - yes, please describe _____
28. Did your knees hit anything during the accident? -no - yes, please describe _____
29. Did your feet hit anything during the accident? -no - yes, please describe _____
30. What kind of headrest was in your vehicle?
    - movable fixed headrest
    - non-movable fixed headrest
    - no headrest
31. Where was the top of the headrest positioned on your head? (ie, top, middle or base of head)

_____

32. Did you have your seatbelt on during the accident? - yes - no If yes shoulder belt or lap belt
33. Did you slide out of your seatbelt during the accident? _____
34. What was damaged in your vehicle? (Circle all that apply)
    - windshield - rear bumper - mirror
    - steering wheel - front bumper - knee bolster
    - dashboard - trunk - back right door
    - seat frame - front left door - completely totaled
    - side window - front right door
    - rear window - back left door
35. Choose the items that dented inward
    - floorboards - side door - dashboard
36. Choose the doors that would not open as a result of the accident
    - front left - front right - trunk
    - rear left - rear right - hatch/back door
37. Did you go to the hospital? (If no, why and do not answer 38-43) - yes -no

_____

38. How did get to the hospital? _____
39. What was the name of the hospital? _____
40. Were you hospitalized overnight? _____
41. Circle what you were prescribed at the hospital
    - pain medication - muscle relaxers - neck brace
42. Did you receive any stitches for any cuts at the hospital? _____
43. Were x rays taken at the hospital? If yes, which area was taken?

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