SCOTT S. SARDONICUS, DC

215 BROWNS RIDGE RD; OSSIPEE NH 03864

AUTO ACCIDENT HISTORY

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Other _____

If a traffic violation was issued, to whom was it issued? _____

People involved in accident: _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing your seatbelt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest?

☐ Above ☐ Below ☐ Other _____

What did your vehicle impact? ☐ Another Vehicle ☐ Other

_____

Approx speed of your vehicle: _____ Other vehicle: _____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

In which direction were they headed? ☐ N ☐ S ☐ E ☐ W

Location/ street: _____

Did any part of your body strike anything? ☐ Yes ☐ No

If yes, describe: _____

Make & model of your vehicle: _____

Make & model of other vehicle: _____

Were you: ☐ aware ☐ surprised by the impact?

Did the impact of your vehicle come from: ☐ Front ☐ Rear

☐ Right Side ☐ Left Side ☐ Other _____

Did the accident render you unconscious? ☐ Yes ☐ No

If yes, for how long: _____

Please describe the accident: _____

_____

_____

What was your body position when the accident occurred: _____

How did you feel:

immediately after the accident (please include emotional and physical reactions): _____

_____

_____

a few hours after the accident: _____

_____

_____

the next day: _____

_____

_____

currently: _____

_____

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & Goes _____

What have you done to try to relieve your symptoms? _____

_____

_____

Have you gone to a hospital or seen any other doctor? ☐ Yes ☐ No If yes, when did you go: _____

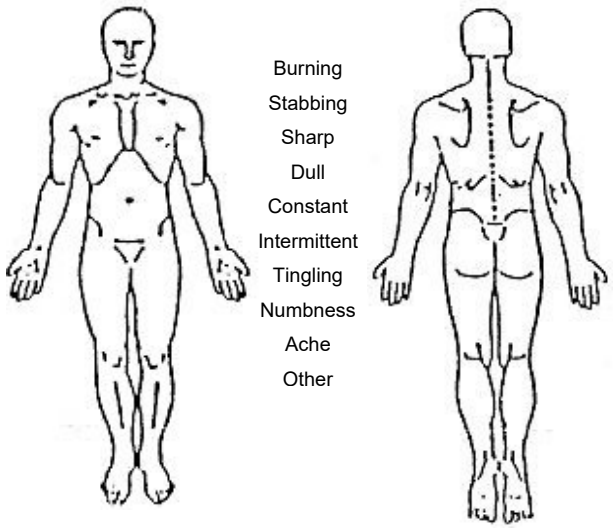
Who did you see and what diagnoses and/or treatment did you receive: _____

_____

_____

Were x-rays taken? ☐ Yes ☐ No What parts of your body did they x-ray: _____

Please mark areas of pain or discomfort on the illustration. Circle the word descriptions of what you're experiencing.



Rate your ability to perform your normal activities (work, play, sports, housework, driving, sitting, walking, sleeping etc)

UNABLE 1 2 3 4 5 6 7 8 9 10 FULLY ABLE

Describe any limitations: _____

_____

_____

_____

Additional comments/concerns: _____

_____

_____

_____

Have you retained an attorney? ☐ Yes ☐ No If yes, name and phone: _____

_____

_____ _____

Signature Date