

**PRO-ACTIVE CHIROPRACTIC
DR. BRIAN SCHUESSLER, DC
AUTO ACCIDENT REPORT
AUTO ACCIDENT HISTORY FORM**

**ARE YOU CURRENTLY OFF WORK DUE TO THIS ACCIDENT YES NO
IF YES, PLEASE EXPLAIN**

**TYPE OF WORK OFFICE/ CLERICAL LIGHT LABOR MODERATE LABOR HEAVY LABOR
DO YOU HAVE ANY PREVIOUS WORK COMP INJURIES YES NO
IF YES, PLEASE EXPLAIN**

**DO YOU HAVE ANY PREVIOUS AUTO ACCIDENT INJURIES YES NO
IF YES, PLEASE EXPLAIN**

**DO YOU HAVE ANY PREVIOUS SPORTS OR OTHER INJURIES TO THE HEAD, NECK, OR BACK
YES NO
IF YES, PLEASE EXPLAIN**

**WAS THE ACCIDENT ON-THE-JOB YES NO
YOU WERE DRIVER FRONT SEAT PASSENGER REAR SEAT PASSENGER MOTORCYCLE
OPERATOR MOTORCYCLE PASSENGER OTHER _____
VEHICLE DRIVEN BY**

YOUR VEHICLE - YEAR _____ MAKE _____ MODEL _____

**YOUR ESTIMATED SPEED AT MOMENT OF ACCIDENT ____MPH STOPPED SLOWING
 ACCELERATING**

OTHER VEHICLE (IF APPLICABLE) YEAR _____ MAKE _____ MODEL _____

TIME OF DAY DAYLIGHT DAWN DUSK DARK

ROAD CONDITIONS DRY DAMP WET SNOW ICE OTHER _____

HEAD RESTRAINTS NONE INTEGRAL TYPE ADJUSTABLE TYPE UP DOWN DON'T KNOW

IF ADJUSTABLE, WAS THE POSITION ALTERED BY THE ACCIDENT YES NO

WAS THE SEAT BACK ADJUSTMENT ALTERED BY THE ACCIDENT YES NO

WAS THE SEAT BROKEN YES NO

LAP BELT WEARING NOT WEARING DON'T KNOW

SHOULDER BELT NONE WEARING NOT WEARING DON'T KNOW

DID AIR BAG DEPLOY YES NO

IF YES, WERE YOU STRUCK YES NO

BODY POSITION GOOD FORWARD LEAN OTHER _____

HEAD POSITION FORWARD LEFT RIGHT UP DOWN

HANDS ONE ON WHEEL TWO ON WHEEL N/A

BRAKES APPLIED YES NO

WERE YOU AWARE OF IMPENDING CRASH YES NO

DURING THE CRASH:

DID YOU STRIKE ANY PARTS OF THE VEHICLE YES NO

IF YES, DESCRIBE

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DID THE VEHICLE STRIKE ANY OBJECTS AFTER THE CRASH YES NO
IF YES, DESCRIBE

WERE YOU WEARING A HAT OR GLASSES YES NO
IF YES, WERE THEY STILL ON AFTER THE CRASH YES NO
DID YOU LOSE CONSCIOUSNESS YES NO
IF YES, FOR HOW LONG

ESTIMATED PROPERTY DAMAGE TO YOUR VEHICLE

\$

ESTIMATED DAMAGE TO OTHER VEHICLE NONE MINIMAL MODERATE MAJOR
WERE POLICE ON SCENE YES NO
IF YES, WAS A REPORT MADE YES NO

AFTER THE CRASH:

SYMPTOMS HEADACHE DIZZINESS NAUSEA CONFUSION/ DISORIENTATION NECK PAIN
 PARESTHESIA(S)

IF YES, WHERE

EXTREMITY PAIN YES NO

IF YES, DESCRIBE

BACK PAIN YES NO

IF YES, DESCRIBE

WHEN DID SYMPTOMS FIRST APPEAR IMMEDIATELY LATER - HOW MUCH LATER
____HRS

WHICH SYMPTOMS APPEARED WHEN?

WHERE DID YOU GO AFTER THE ACCIDENT HOME WORK HOSPITAL YOUR DOCTOR
MODE OF TRANSPORTATION

IN THE SPACE PROVIDED BELOW PLEASE **DRAW** A DIAGRAM OF THE ACCIDENT