

**Cantalupo Chiropractic  
Supplemental Personal Injury / Automobile Accident Form (1)**

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

At time of accident: Employer: \_\_\_\_\_ Work phone # \_\_\_\_\_

Current employer? \_\_\_\_\_ Unemployed? Y N Due to accident? Y N

**\*\*\*Note: Circle, check- off or "fill- in" correct response. Leave no blanks!  
Accuracy is essential!**

**Accident Details:**

**Date of injury:** \_\_\_\_/\_\_\_\_/\_\_\_\_. Time of day \_\_\_\_\_ AM / PM

Were you "**on the job**" at the time of the crash? Y N

**Describe "in your own words" exactly how this crash happened:** \_\_\_\_\_

**Were you the :**  driver  passenger: in front? / rear seat?  motorcycle : driver? / passenger?  
other: \_\_\_\_\_

**Vehicle driven by:** \_\_\_\_\_ **Vehicle make, model & yr.** \_\_\_\_\_

Was **anyone else in the vehicle** with you? Y N . If yes, who? \_\_\_\_\_

**My estimated speed** at time of impact was \_\_\_\_\_ mph. **I was:** stopped / slowing / accelerating

**Other vehicle:** make, model & yr.: \_\_\_\_\_

**Time of day:** daylight dawn dusk dark

**Road condition:** dry damp wet snow ice hailing other \_\_\_\_\_

**My seat headrest:**  was adjustable  not adjustable. **It was:** up / down / I don't recall

**If it was adjustable:** was it's original position changed by the crash? Y N

Was the "**seat back**" **position altered** by the crash? Y N . Was it **broken** by the crash? Y N

**Lap/seat belt:** used not used don't recall . **Shoulder belt:** used not used don't recall

**Body position** at time of impact?  Good  leaning forward  other: \_\_\_\_\_

**Head position?** Looking forward? Turned: Right? or Left? looking up? looking down?

**Hand position:** one on the wheel two on the wheel  don't remember

**At time of crash, brakes applied?** Y N

**What direction** was the crash impact in relation to where you were seated (circle one)?

Front / rear / left side / right side or left front / left rear / right front / right rear .

**During the Crash**

**If your car has an airbag, did it deploy?** Y N . If yes, were you struck by it? Y N.

Were you taken by surprise ( **unaware of the impending crash**) Y N

Did any part of your **body strike any part of the vehicle?** Y N, If yes, describe: \_\_\_\_\_

Did you **lose consciousness?** Y N. If yes, how long? \_\_\_\_\_

Did **vehicle strike any objects** after the crash? Y N . Were you **wearing a hat or glasses?** Y N

Were they **still on after the crash?** Y N .

Estimated property **damage to your vehicle** \$ \_\_\_\_\_.  I don't know

Estimated **damage to other vehicle:** none minimal moderate major  I don't know

Were the **police on the scene?** Y N If so, did they **make a report?** Y N

Who, if anyone, **received a ticket or citation** from the police regarding this crash? \_\_\_\_\_

**Please turn over to complete this form!**

**After the crash:**

**Immediately after the crash**, did you go : home work hospital doctor \_\_\_\_\_  
Were you **taken by ambulance** anywhere? Y N If yes, where? \_\_\_\_\_  
Were you : admitted to the hospital?  received *treatment in the emergency room* & released  
**What was done there?**  Exam  x-rayed  given medicine  collar/ brace  
If x-rayed, **what body parts** were imaged?: \_\_\_\_\_  
If given **medication: name and dosage**- \_\_\_\_\_  
Any **follow up instructions** given? If yes, what were they? \_\_\_\_\_

**Have you seen any other doctor's before coming here?** Y N . If yes, complete this section.  
Dr. \_\_\_\_\_ specialty \_\_\_\_\_ treatment \_\_\_\_\_  
Dr. \_\_\_\_\_ specialty \_\_\_\_\_ treatment \_\_\_\_\_  
Dr. \_\_\_\_\_ specialty \_\_\_\_\_ treatment \_\_\_\_\_  
Dr. \_\_\_\_\_ specialty \_\_\_\_\_ treatment \_\_\_\_\_  
Notes: \_\_\_\_\_

Have you **missed work due to this injury?** Y N.. From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.

**Did you have any of the following symptoms following the crash:**

**Headache neck pain dizziness nausea confusion/disorientation**  
**Other:** \_\_\_\_\_  
**Numbness/tingling:** if yes, where? \_\_\_\_\_  
**Pain in arms/legs:** If yes, where? \_\_\_\_\_  
**Back pain?** Where? \_\_\_\_\_  
List symptoms that appeared **immediately:** \_\_\_\_\_  
List symptoms that **appeared later:** \_\_\_\_\_  
-How long after the initial crash? \_\_\_\_\_

**Past History of injury:**

Did you have **any of these symptoms immediately prior to this crash?** Y N , If yes, please explain: \_\_\_\_\_  
**To the best of your recollection**, do you recall any **previous accidents / injuries?** Y N .  
**If yes, list any** that resulted in **bodily injury:** \_\_\_\_\_

Did they **require extensive ongoing treatment?** If yes, explain: \_\_\_\_\_

Do you have any **disabling conditions or physical impairments** that are not related to this injury? Y N If yes, Explain: \_\_\_\_\_

**Insurance/Legal information**

Was your *vehicle insurance in effect and up to date* at the time of the accident?\_ Y N  
Auto insurance co. name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ Policy number \_\_\_\_\_  
Do you have *medical payments coverage* on your auto policy? Y N. If yes, how much \$ \_\_\_\_\_

Do you have *regular health insurance?* Y N Insurance. Co name \_\_\_\_\_  
Policy # \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_  
Have you *hired an attorney* to represent you? If yes,... Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

**By signing this form I attest that this information is complete and accurate to the best of my knowledge. I also agree to provide the name and contact information of any attorney I hire.**  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_