COBB CHIROPRACTIC CLINIC

AUTOMOBILE ACCIDENT INJURY REPORT

DATE:____________________

PATIENT NAME: ____ CHART #:_____________

DATE OF ACCIDENT:___________TIME:_________ AM/PM LOCATION:__________________

PLEASE DESCRIBE HOW THE ACCIDENT HAPPENED: _____________________________________
____
____
____

AT THE TIME OF THE ACCIDENT WERE YOU WEARING YOUR SEAT BELT? YES / NO

WERE YOU THE: DRIVER_________ PASSENGER____________ PEDESTRIAN__________

WERE YOU STRUCK FROM: BEHIND______ RIGHT_______ LEFT_______ FRONT________

DID YOU STRIKE THE OTHER CAR(S) OR DID THE OTHER CAR STRIKE YOU?_________________

DID POLICE COME TO THE SCENE? YES / NO IS THERE A REPORT? YES / NO

WERE YOU AWARE OF THE IMPENDING COLLISION? YES / NO

WAS YOUR CAR STOPPED AT IMPACT? YES / NO WAS YOUR FOOT ON THE BRAKE? YES / NO

IF YOU WERE THE DRIVER WAS YOUR FOOT ON THE BRAKE? YES / NO

WAS YOUR HEAD OR BODY TURNED AT TIME OF COLLISION, IF YES: LEFT / RIGHT

HEADREST WAS: BELOW YOUR HEAD_______ABOVE YOUR HEAD:_______ LEVEL:_______

ROAD CONDITIONS: DRY_________ WET___________ ICY___________ OTHER_________

WERE YOU ADMITTED TO THE HOSPITAL? IF YES WERE YOU TREATED IN THE EMERGENCY ROOM?

YES / NO HOSPITAL NAME :____

COBB CHIROPRACTIC CLINIC 1001 N. ELM ST. GREENSBORO, NC 27401

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

SHORTNESS OF BREATH ___________

EXCESSIVE PERSPIRATION__________

MID BACK (PAIN/STIFFNESS) _________

LOW BACK(PAIN/STIFFNESS) _________

SWELLING (WHERE) _______________

COLD HANDS/FEET ________________

RESTRICTION OF NECK MOTION_______

UPPER BACK PAIN/STIFFNESS__________

BUZZING OR RINGING IN EARS________

EYES SENSITIVE TO LIGHT____________

HEAD AND SHOULDERS FEEL TIRED_____

PINS AND NEEDLES (ARMS/LEGS)_______

NUMBNESS (ARMS/LEG/FINGER)________

DIFFICULTY RIDING IN CAR____________

HEADACHE________________________

NECK PAIN / STIFFNESS_______________

INSOMNIA__________________________

TENSION___________________________

IRRITABILITY________________________

DOUBLE VISION_____________________

DIGESTIVE DISORDERS_______________

EQUILIBRIUM PROBLEMS_____________

LOSS OF TASTE________

LOSS OF SMELL________

LOSS OF MEMORY_____

DIARRHEA___________

NEURITIS___________

ANXIETY____________

FAINTING___________

CHEST PAIN_________

DIZZINESS___________

CONSTIPATION_______

DEPRESSION_________

EYE STRAIN__________

NAUSEA / VOMIT______

FACE FLUSHED________

PALPATATIONS__________

TREMORS____________

SINUS TROUBLE_______

MENTAL DULLNESS_____

NERVOUSNESS_________

FATIGUE_____________

PAIN BEHIND EYES______

REDUCED HEAT TOLERANCE____

DIFFICULTY IN

STANDING_____

RIDING________

WALKING______

BENDING______

PAIN RADIATING INTO

ARM____ LEG___

RIGHT___ LEFT___

BOTH__________

DIFFICULTY IN LIFTING:

LIGHT_____ HEAVY___

MODERATE__________

PAIN RADIATING INTO:

BASE OF SKULL____

SHOULDER________

NECK____________

ARMS___________

HIPS_____________

LEGS_____________

HEAVY HEAD_________

DISORIENTED________