Scott R. Lenz, D.C.
Chiropractic Physician

Lenz Chiropractic, PC
Automobile Accident History Form

Leigh F. Lenz, D.C.
Chiropractic Physician

Name: _____ Date: _____

Date of Accident:_____Time:_____❑am❑pm

Location:_____

Describe the accident in your own words:_____

_____

_____

_____

Road conditions at the time of accident: ❑ Wet ❑ Dry ❑ Icy ❑ Snow ❑ Other:_____

You were the: ❑ Driver ❑ Passenger ❑ Pedestrian **Passenger position**: ❑ Front ❑ R rear ❑ L rear

The impact was from: ❑ Front ❑ Right side ❑ Left side ❑ Rear

At impact you were facing: ❑ Straight-ahead ❑ Right ❑ Left

Were you aware of the approaching collision prior to impact or were you surprised? ❑Aware ❑ Surprised

Did you experience a flash of light or a feeling of explosion in your head? ❑ Yes ❑ No ❑ Can't remember

Immediately following the accident, did you become:

❑ Confused ❑ Disoriented ❑ Light-headed ❑ Dizzy ❑ Nauseous ❑ Blurred vision ❑ Ring in ears

Were your hands on steering wheel? ❑ Yes ❑ No **Foot on Brake?** ❑ Yes ❑ No

Were you braced for impact? ❑Yes ❑ No **Seat belts on?** ❑ Yes ❑ No

If you have an airbag in your car, did it inflate on impact? ❑ Yes ❑ No ❑ N/A

Shoulder restraint – was it shoulder/lap combination? ❑ Yes ❑ No

Did you receive any injury or bruise from the seatbelt? ❑ Yes ❑ No If yes, describe: _____

Did you strike anything in vehicle at impact? ❑ Yes, specify_____❑ No

Did you lose consciousness? ❑ Yes ❑ No If yes, how long?_____

Name(s) of other people in your car: 1._____2._____3._____

Was there police investigation at the scene? ❑Yes ❑No **Citation issued?** ❑Yes ❑No **To whom?**_____

Did you go to a hospital/emergency center? ❑Yes ❑No If yes, where:_____when:_____

How did you get to hospital? _____Name of attending doctor?_____

Treatment rendered:_____ Release same day? ❑Yes ❑No If no, when:_____

Doctor's recommendations, if any:_____

Have you seen any other doctor as a result of this accident? ❑ Yes ❑ No Dr.'s name:_____

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CHECK SYMPTOMS YOU HAVE HAD SINCE ACCIDENT:

			L	R		
❑Headache	❑Constipation	❑Hip pain	❍	❍	❑Shortness of breath	❑Diarrhea
❑Neck pain	❑Chest pain	❑Leg pain	❍	❍	❑Fatigue	❑Feet cold
❑Neck stiff	❑Stomach upset	❑Knee pain	❍	❍	❑Depression	❑Hands cold
❑Fever	❑Head heavy	❑Ankle pain	❍	❍	❑Lights bother eyes	❑Regional swelling
❑Back Pain	❑Arm pain	❑Foot pain	❍	❍	❑Face flushed	❑Urinary difficulties
❑Nervousness	❑Elbow pain	❑Pins & needles in arm			❑Loss of balance	❑Sexual dysfunction
❑Cold sweats	❑Wrist pain	❑Pins & needles in leg			❑Fainting	❑_____
❑Tension	❑Hand pain	❑Numbness in fingers			❑Loss of smell	❑_____
❑Ears ring	❑Shoulder pain	❑Numbness in toes			❑Loss of taste	❑_____

Has this part been injured before? ❑ Yes ❑ No If yes, has this part been injured before? Please describe:

_____

_____

Have you lost any time from work because of this accident? ❑ Yes ❑ No Dates: From _____To_____

Totally disabled from _____to_____ Partially disabled from _____to_____

Are you currently suffering from any of the following: ❑ Mental function difficulties or changes

❑ Restlessness ❑ Irritable ❑ Difficulties concentrating ❑ Difficulties with memory

❑ Difficulties sleeping ❑ Forgetfulness ❑ Reduced tolerance to heat ❑ Intolerance to alcohol

List the year, make and model of the vehicle **you** were in: Year:_____Make:_____Model:_____

Was your car stopped at the time of impact? ❑ Yes ❑ No, estimated speed of vehicle you were in:____MPH

If your vehicle was moving at the time of impact, was it:❑ Slowing down ❑ Speeding up ❑ Maintaining speed

Estimated damage to the vehicle you were in: $_____

List the year, make, and model of the **other** vehicle involved in the accident: Year:_____

Make:_____Model:_____

Was the other vehicle moving at time of impact? ❑ Yes ❑ No If yes, what was approximate speed?___MPH

Was the other car: ❑ Slowing down ❑ Speeding up ❑ Maintaining steady speed

Any other comments about accident or injuries:_____

Your auto insurance company:_____Address_____Policy #_____

Other driver's insurance co._____Address_____Policy #_____

Have you been contacted by an insurance adjustor or company representative on this claim? ❑ Yes ❑ No

Have you filled out your Personal Injury Protection (PIP) Application since the accident? ❑ Yes ❑ No

Do you have an attorney who has advised you in this case?❑ Yes ❑ No Name:_____

I hereby authorize Lenz Chiropractic, PC to release medical information necessary to process this claim.

Patient Signature:_____ Date:_____