Automobile Accident History Form

Vancouver West Chiropractic Clinic
300-2245 West Broadway
Vancouver, BC, V6K 2E4
604-732-0664
drspence@telus.net

Personal Information

Last Name: _____ First Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Accident information

City of Accident: _____ Time of Accident: _____ ◯ AM ◯ PM Date of Accident:

Street of Accident:: _____

ICBC and Legal information

ICBC Adjustor's Name: _____ Phone #: _____ Claim #: _____

Lawyer's Name: _____ Phone #: _____

Accident and Injury information

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

Did the police come to the accident scene? ◯ Yes ◯ No If yes, is there a report? ◯ Yes ◯ No

Did you go to the hospital? ◯ Yes ◯ No

If Yes

Name and city of hospital: _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay in the hospital? _____

What bleeding cuts did you sustain from the accident? _____

What bruises did you sustain during the accident? _____

Where were you seated in the vehicle? _____

Where you aware of the approaching collision prior to impact or were you surprised _____

Did you lose consciousness (black out) upon impact? ◯ Yes ◯ No If yes, how long? _____

Did you experience a flash of light or explosion in your head? ◯ Yes ◯ No

Did you suffer any of the following from the accident (check all that apply).

☐ Dizzy ☐ Nauseated ☐ Blurred Vision ☐ Ring/Buzz in Ears ☐ Confused ☐ Disoriented ☐ Lightheaded

If you still have any of the previous symptoms, which ones? _____

Are you currently suffering from any of the following (check all that apply). ☐ Restlessness ☐ Irritable ☐ Difficulty with Memory ☐ Difficulty Concentrating ☐ Forgetfulness ☐ Sleeplessness ☐ Reduced Tolerance to Heat ☐ Reduced Tolerance to Alcohol

How far is the top of the headrest of seat back from the top of your head? _____ inches ◯ above ◯ below

Were you wearing a seat belt? ◯ Yes ◯ No If YES What kind of seat belt was it? _____

What kind of vehicle were you in? Year _____ Make _____ Model _____

Was your car stopped at the time of impact? ◯ Yes ◯ No If YES was the driver's foot also on the brake? ◯ Yes ◯ No

If NO, estimate the speed of the vehicle you were in _____

continued from page 1

If your vehicle was moving at the time of impact, was it: _____

if your body hit any part of the automobile please explain what body part(s) where hit and what they hit:

_____

_____

Did you receive any injury or bruise from the seat belt? ◯ Yes ◯ No

If YES, then describe: _____

What is the estimated cost damage to the vehicle you were in? _____

Which of the following car parts broke during the accident? ☐ Windshield ☐ Front Seat ☐ Right/Left side window

☐ Steering wheel Other - describe _____

Was the trunk of your body pointed straight forward at the time of the collision? ◯ Yes ◯ No

If NO, how were you positioned? _____

Was your head pointed straight forward? ◯ Yes ◯ No

If NO, what direction was it turned and by how much? _____

Other vehicle(s) information: Year _____ Make _____ Model _____

Was the other vehicle moving at the time of collision? ◯ Yes ◯ No If YES, how fast? _____ Km/h

If the other vehicle was moving at the time of collision, was it: ☐ slowing down ☐ gaining speed ☐ travelling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

_____

_____

Submit by Email Print Form