Injury History	
Was the crash on-the-job? • Yes • No	Crash description:
You were: O Driver O Front seat passenger	
O Rear seat passenger O Motorcycle operator	
O Motorcycle passenger O Other	
Vehicle driven by:	
Your vehicle (year, make, model):	
Your estimated speed at moment of crash:	
O Stopped O Slowing O Accelerating	Aware of impending crash? O Yes O No
Other vehicle (year, make, model):	
Time of day: O Daylight O Dawn O Dusk O Dark	During the Crash:
Road conditions: O Dry O Damp O Wet O Snow	Did you strike any parts of the vehicle? O Y O N
○ Ice ○ Other	If yes, describe
Head restraints: O None O Integral type O Adjustable type:	Did vehicle strike any objects after crash? O Y O N
O Up O Down O Don't know	If yes, describe
If adjustable, was the position altered by the crash?	Wearing hat or glasses? O Y O N
○ Yes ○ No	If yes, still on after crash? O Y O N
Was the seat back adjustment altered by the crash?	Did you lose consciousness? O Y O N
○ Yes ○ No	If yes, for how long?
Was the seat broken? • Yes • No	Estimated property damage to your vehicle: \$
Lap belt: O Wearing O Not wearing O Don't know	Estimated damage to other vehicle(s):
Shoulder belt: O None O Wearing O Not wearing	O None O Minimal O Moderate O Major
O Don't know	Were the police on-scene? O Y O N
Did air bag deploy? • Yes • No	If yes, was a report made? O Y O N
If yes, were you struck? O Yes O No	After the Crash:
Body position: O Good O Forward lean	Symptoms: O Headache O Dizziness O Nausea
O Other	O Confusion/disorientation O Neck pain O Paresthesia(s)
Head position: O Forward O Left °	If yes, where?
○ Right ° ○ Up ° ○ Down °	O Extremity pain. If yes, where?
Hands: O One on wheel O Two on wheel O N/A	O Back pain
Brakes applied? O Yes O No	When did SX first appear? O Immediately
Crash Diagram	(describe which SX) hr afterward
	Where did you go after crash? O Home O Work
	O Hospital:
	Mode of transportation:
	Pvt. doctor:
	Emergency Department:
	Radiographs: ""Yes """No
	Body parts imaged
	Results
	Lab work O Yes O No
	O Cervical collar O Ice
	Medications:
	Follow-up instructions: O None
	Body parts imaged Results Lab work O Yes O No O Cervical collar O Ice Medications: Other:

Doctor's Notes:	
Other Vehicle type:	
	Your Insurance Coverage
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Name of Injured:	Date of Injury:
City of Accident:	Claim #:
Insurance Company:	Insurance Rep:
	Policy #:
	Relation to Injured:
Claims Address:	
dations for your care will be based upon your evalua	e insurance plans have serious limitations to care. It's important for you to know that all recommen- ation not based on your insurance coverage. Health Enhancement Chiropractic takes pride in giv- ased on our experience in handling cases like yours.
Patient's Signature:	Date of Acceptance:
Patient's Name (Please Print):	