

**CLEAR CREEK
CHIROPRACTIC
C E N T E R**

PERSONAL INJURY

Name _____ Sex _____ DOB _____

Address _____
Street City St Zip

Date and time of accident? _____

Road conditions and visibility? _____

Name of Auto Insurance Company: _____ Policy# _____

Year/Make/Model of car you occupied: _____

Position in car/description: _____

Was the vehicle: Moving Stopped Rolling Accelerating Decelerating Seat Belts? Yes No

Year/Make/Model of other car(s) involved: _____

Direction Traveling: North East South West

Police Respond: Yes No Was a police report filed? Yes No EMT's respond? Yes No

Were any tickets issued? Yes No If yes, to whom: _____

Where were you taken after the accident? _____

What are of the car was impacted? _____

Did you anticipate the collision? Yes No Did you brace for impact? Yes No

Where were your hands positioned? _____

Which direction was your head facing? Forward To the right To the left Behind Up Down

Did the airbags deploy? Yes No Were objects thrown in the car? _____

Were any of your body parts struck in the collision? _____

If so, what part of the car did your body strike? _____

Where did you feel pain? _____

**Clear Creek Chiropractic Center
624 W. Main Suite 102, League City, TX, 77573
(281) 525-4130**

www.clearcreekchiro.com

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What are your current symptoms? _____

How did you feel immediately following the Collision? Stunned Disoriented Lost consciousness

Felt tightness Discomfort Pain Frightened Popping/ripping sensation

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling

Cramps Stiffness Swelling Other _____

Is pain: Occasional? Intermittent? Constant? Rate severity of pain from 0 to 10 _____

Does it interfere with your: Work Sleep Daily Routine Recreation

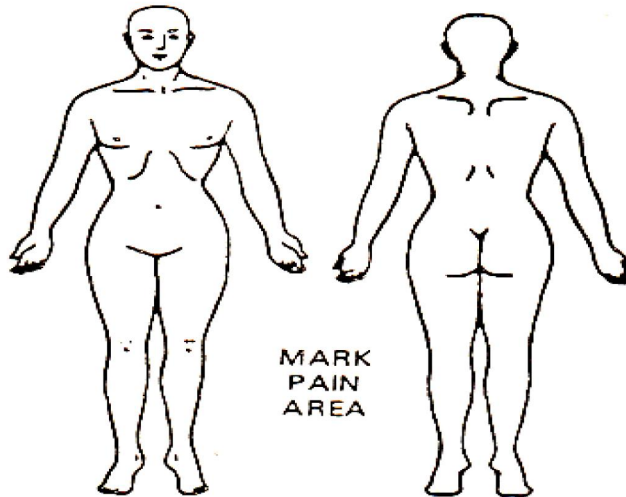
Activities/movements that are painful to perform: _____

What helps pain? _____

Name of any other doctor consulted since your accident _____

Treatment received? _____

Please indicate on the picture where you feel pain/discomfort:



Patient Signature: _____ Date: _____

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