This form is fillable in most programs but not in Microsoft Edge. It does NOT automatically save your entries. If you are able to type, fill it out here. If you cannot type into it, DOWNLOAD this form to your computer and open it in Adobe Reader - not in your browser. Instructions for sending it to Dr. Gibson are on the last page. Thanks!

EPC AUTOMOTIVE CRASH FORM

General Information

Patient Name: _____

Date of injury: _____ Time of injury:____:____ ◯ AM ◯ PM

City & Street where crash occurred: _____

What is the estimated damage to your vehicle? _____

Have your reported injury to your car insurance company? ☐ Yes ☐ No

Do you have automobile medical insurance coverage? ☐ Yes ☐ No

Company name/address/phone: _____

What is your car insurance medical coverage limit? _____

What is the claim number?_____

Claim adjuster name (if you know it) _____

Did the police come to the accident scene and make a report? ☐ Yes ☐ No

Is an attorney representing you? ☐ Yes ☐ No

name/address/phone _____

Accident Specifics

Please describe how the accident happened:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please check what applies:

Were you the: ☐ Driver ☐ Passenger

If you were the passenger, where in the car were you located?

☐ Front ☐ Middle ☐ Rear

☐ Left ☐ Middle ☐ Right

Your vehicle type:

☐ Car ☐ Van ☐ Pick-Up ☐ Truck

☐ Bus ☐ SUV ☐ Motorcycle

☐ Other _____

Your vehicle size:

☐ Mini ☐ Sub-Compact ☐ Compact

☐ Mid-size ☐ Full-size

At the time of the accident your car was:

☐ Stopped ☐ Slowing ☐ Accelerating

☐ Cruising

Your speed: _____ MPH

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Road Condition: ☐ Dry ☐ Damp ☐ Wet ☐ Snowy ☐ Icy

Visibility: ☐ Good ☐ Fair ☐ Poor

Your car impacted with a: ☐ Vehicle ☐ Object

If it was a vehicle, that vehicle was a:

☐ Car ☐ Van ☐ Pick-Up ☐ Truck

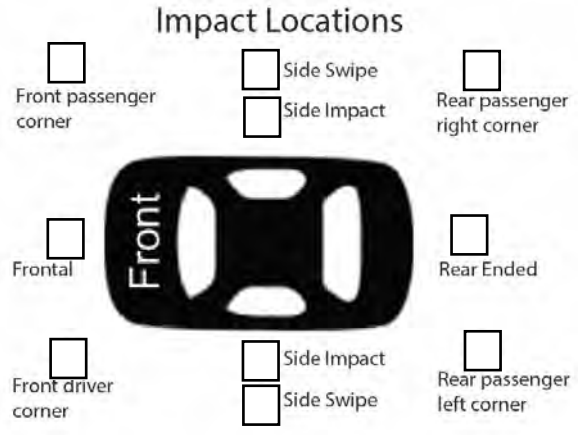
☐ Bus ☐ SUV ☐ Motorcycle

☐ Other _____

Its size:

☐ Mini ☐ Sub-Compact ☐ Compact

☐ Mid-size ☐ Full-size



Please mark the point(s) of impact to your car and/or describe impact location:

_____

_____

Damage to your vehicle:

☐ Minimal ☐ Moderate ☐ Extensive

☐ Totaled ☐ Unsure

Information About DURING IMPACT

Were you wearing a seat belt? ☐ Yes ☐ No
Did the airbag deploy? ☐ Yes ☐ No
Where was your headrest? ☐ Low ☐ Mid ☐ High ☐ None
Did the seat back position change? ☐ Yes ☐ No
Were the brakes applied? ☐ Yes ☐ No
Seat broken? ☐ Yes ☐ No

When the impact happened, was it:
☐ Unexpected ☐ Expected ☐ Expected and you braced for it

During impact, your body position was:
☐ Straight ☐ Rotated left ☐ Rotated Right
☐ Unsure ☐ Other _____

Was your body thrown from the seat? ☐ Yes ☐ No
If so, what direction: ☐ Backwards ☐ Forward ☐ Outside
☐ Unsure ☐ Other _____

During impact, your head position was:
☐ Straight ☐ Rotated left ☐ Rotated Right
☐ Unsure ☐ Other _____

During impact, the motion of your head was:
☐ Forwards to Backwards ☐ Backwards to Forward
☐ Right to Left ☐ Left to Right ☐ Unsure
☐ Other _____

Where was your body impacted?
☐ Head
☐ Left Shoulder ☐ Right Shoulder
☐ Left Arm ☐ Right Arm
☐ Left Elbow ☐ Right Elbow
☐ Left Hand ☐ Right Hand
☐ Upper Front Torso ☐ Mid-Torso ☐ Lower Front Torso
☐ Upper Back ☐ Mid-Back ☐ Lower Back
☐ Left Leg ☐ Right Knee ☐ Right Foot
☐ Right Leg ☐ Left Knee ☐ Left Foot
Other: _____

_____

_____

Information About AFTER the Impact

Immediately after accident were you:

☐ dizzy/dazed ☐ upset ☐ weak ☐ nervous
☐ headaches ☐ disoriented ☐ unconscious
Other: _____

_____

After the impact, there was pain in your:

☐ Head
☐ Left Shoulder ☐ Right Shoulder
☐ Left Arm ☐ Right Arm
☐ Left Elbow ☐ Right Elbow
☐ Left Hand ☐ Right Hand
☐ Upper Front Torso ☐ Mid-Torso ☐ Lower Front Torso
☐ Upper Back ☐ Mid-Back ☐ Lower Back
☐ Left Leg ☐ Right Knee ☐ Right Foot
☐ Right Leg ☐ Left Knee ☐ Left Foot
Other: _____

_____

There was numbness in your:

☐ Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg
☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐Right Foot
Other: _____

_____

Medical Care

Did you receive medical care: ☐ Yes ☐ No

If yes, when did you receive it: ☐ Next day ☐ At time of accident
☐ Later that day
☐ Days later #_____

How were you transported to medical care? ☐ Drove self ☐ Ambulance
☐ Other _____

You went to: ☐ Orthopedic ☐ Chiropractor ☐ Neurologist
☐ Family Doctor ☐ Emergency Room
☐ Other _____

Were you admitted to the hospital? ☐ Yes ☐ No Days spent in hospital:_____

What kind of tests were run on you?
☐X-Rays ☐ Lab Work ☐ MRI ☐ CT Scan
☐ Other _____

_____

You were treated with:
☐ Ice Packs ☐ Hot Packs ☐ None
☐ Cervical Collar ☐ Medication
☐ Other: _____

_____

Information about Previous Injuries

Have you had any previous injuries/accidents? ☐ Yes ☐ No

Explain: _____

_____

_____

Do you have residual pain from any previous injuries/accidents? ☐ Yes ☐ No

Explain: _____

_____

_____

Information About SYMPTOMS You Experienced AFTER the accident

In your **Head**, please check any symptoms:

☐ Headaches ☐ Loss of memory ☐ Light headedness
☐ Fainting ☐ Blurred vision ☐ Double vision
☐ Dizziness ☐ Pain in ear ☐ Loss of vision
☐ Other _____

In your **Neck**, please check any symptoms:

☐ Pain
☐ Muscle spasms
☐ Popping

If there is pain in your neck, it occurs when you move your head/neck:

☐ Forward ☐ Backward ☐ Turn Left
☐ Turn Right ☐ Bend Left ☐ Bend Right
☐ Other: _____
_____

In your **Shoulders**, please check any symptoms:

☐ Pain in the shoulder joint ☐ Can't raise arms above shoulder level
☐ Pain across the shoulder ☐ Can't raise arms over head
☐ Tension in shoulders
☐ Muscle spasms in shoulders
☐ Other: _____

In your **Mid Back**, please check any symptoms:

☐ Sharp stabbing ☐ Mid back pain ☐ Pain from front to back
☐ Dull ache ☐ Muscle spasms ☐ Pain between blades
☐ Pain in kidney area
☐ Other: _____

In your **Lower Back**, please check any symptoms:

☐ Low back pain ☐ Muscle spasms in lower back

Lower back pain is worse when:

☐ Working ☐ Lifting ☐ Stooping ☐ Standing
☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down
☐ Other: _____

In your **Hips, Legs & Feet** please check any symptoms:

☐ Pain in buttocks ☐ Pins and needles in legs ☐ Pain down leg
☐ Pain in hip joint ☐ Feet feeling cold ☐ Swollen feet
☐ Numbness of toes ☐ Numbness of leg ` ☐ Knee pain
☐ Leg cramps ☐ Cramps in feet
☐ Other: _____

In your **Arms and Hands**, please check any symptoms:

☐ Pain in fingers ☐ Numbness in left arm
☐ Pins and needles in hand ☐ Numbness in right arm
☐ Pins and needles in finger ☐ Cold hands
☐ Swollen joints in finger ☐ Loss of grip strength
☐ Other: _____

In your **Chest**, check any symptoms:

☐ Chest Pain ☐ Pain around ribs ☐ Shortness of breath
☐ Breast pain
☐ Other: _____

In your **Abdomen**, check any symptoms:

☐ Nervous stomach ☐ Nausea ☐ Diarrhea
☐ Gas ☐ Constipation
☐ Other: _____

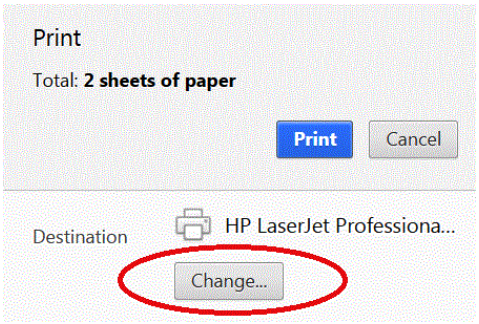
Please check any other **General** symptoms:

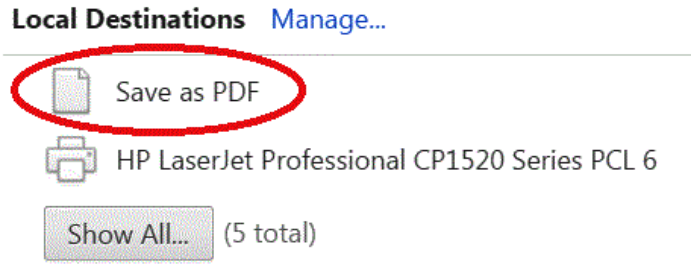
☐ Nervousness ☐ Fatigue
☐ Irritable ☐ Depressed
☐ Generally feel run down ☐ Prostate pain/swelling
☐ Difficulty urinating ☐ Night urination problems
☐ Cramping ☐ Irregularity
☐ Loss of sleep if so, hours per night:_____
☐ Loss of weight if so, approx pounds:_____
☐ Gain of weight if so, approx pounds:_____
☐ Other: _____

_____

You're done! Here's how to save your data and get it to Dr. Gibson:

If you have filled out this form in Google Chrome, 'saving' will not keep your entries.
Instead, CLICK 'Print.' CHANGE the destination from your printer to "Save as PDF." (See picture.)
Then instead of printing on paper, your pages get saved to a file.
EMAIL that file to drgibson@eastonpondchiropractic.com





In Internet Explorer, Adobe Reader, and many other softwares, just try SAVING the form.
Double check that your data shows up in the new file before closing your work.
EMAIL that form to drgibson@eastonpondchiropractic.com.

Clicking the yellow button below might also work, depending on the type of email you use. Try it!

Email to Dr. Gibson