Pearson & Weary
CHIROPRACTIC ORTHOPEDICS AND REHABILITATION

Pain Relief Clinics

Please complete ONLY if you were in a Car Accident

Date of Collision: _____ Year Make and Model of your car:_____

Year Make and Model of the other car: _____

Were you struck from : ◯ Behind ◯ Left side ◯ Right side ◯ Front

Were you moving: ◯ Yes ◯ ◯ No If yes, approximate speed: _____

Were your brakes applied: ◯ Yes ◯ No Were you the driver: ◯ Yes ◯ No Were you the passenger: ◯ Yes ◯ No

Were there others in the car? ◯ Yes ◯ No How many ? _____

Were you using a seat belt? ◯ Yes ◯ No Shoulder harness? ◯ Yes ◯ No

Do you have a head restraint? ◯ Yes ◯ No What were the road conditions? ◯ Wet ◯ Dry ◯ Snow ◯ Ice

Position of your head at impact? _____ Position of hands at impact? _____

Were you aware of the impending collision? ◯ Yes ◯ No ◯ Uncertain

Did you feel more than one impact? ◯ Yes ◯ No ◯ Uncertain

Did you strike anything inside the car? ◯ Yes ◯ No ◯ Uncertain Please describe:_____

Were you told you were unconscious? ◯ Yes ◯ No ◯ Uncertain

Did you feel dazed? ◯ Yes ◯ No ◯ Uncertain

Where did you go after the accident? _____ Was your car drivable? ◯ Yes ◯ No

If you went to the hospital, how did you arrive? Ambulance or other vehicle _____

What was done at the hospital? X rays? ◯ Yes ◯ No Other imaging? ◯ Yes ◯ No Medication? ◯ Yes ◯ No

Have you had PT ◯ Yes ◯ No What additional care have you had? _____

Was a police report made? ◯ Yes ◯ No What were the estimate damages to your car? _____

Do you have PIP coverage? ◯ Yes ◯ No Do you know if you have any coverage left ? ◯ Yes ◯ No

Please complete ONLY if you were injured On the Job / Labor and Industry claim

Date of Accident: _____ Employer: _____ Self insured? ◯ Yes ◯ No

Job Description: _____

Describe the Accident: _____

Was your manager notified? ◯ Yes ◯ No Was there an injury claim completed? ◯ Yes ◯ No

Name of supervisor_____ Phone number: _____

Were you told you were unconscious? ◯ Yes ◯ No ◯ Uncertain

Did you feel dazed? ◯ Yes ◯ No ◯ Uncertain

Where did you go after the accident? _____ If you went to the hospital, how did you arrive?

Ambulance or other vehicle? _____

What was done at the hospital? X rays? ◯ Yes ◯ No Other imaging? ◯ Yes ◯ No Medication? ◯ Yes ◯ No

Please describe_____

Have you had a similar injury in the past? ◯ Yes ◯ No Please describe_____

Have you lost days of work? ◯ Yes ◯ No How many? _____