## COLLISION INFORMATION Kuns Chiropractic - 405 NE Division, Gresham Or. 97030 503-661-0791

Name:	Today's Date:				
Where did the collision occur: Street:	City:	State:			
Date when collision occurred:	AM or PM. Was the road: 🗅 Dry	□ Wet □ Snowy □ Icy			
Where you the: 🗅 Driver 🗅 Front middle passenger 🗅 Front right passenger 🗅 Back left 🗅 Back middle 🛛 Back righ					
Describe what happened:					

## **CRASH DETAILS**

	Ƴes	🗆 No	If driving, were both hands on the wheel at impact?				
	Yes	🗆 No	If passenger, did your hands brace yourself?				
	Yes	🗆 No	Did you have your seat belt and shoulder strap on?				
	Yes	🗆 No	Was your seat up at the time of impact?				
	Yes	🗆 No	Where you wearing a bulky coat or slippery pants?				
	Yes	🛛 No	Did the seat belt engage?				
	Yes	🛛 No	Did the airbag engage?				
	Yes	🛛 No	Did you hit the dash, steering wheel or window?				
	Yes	🛛 No	Did you know you were going to be hit?				
	Yes	🛛 No	Did you brace yourself with hands or feet?				
	Yes	🛛 No	If driving, was your foot on the brake at impact?				
<b>D</b>	Yes	🗆 No	Was your head turned at impact?				
<b>D</b>	Yes	🗆 No	Were you leaning forward?				
<b>D</b>	Yes	🗆 No	Did your glasses fly-off at impact?				
<b>D</b>	Yes	🗆 No	Was your body turned at the moment of impact?				
<b>D</b>	Yes	🗆 No	Did you get hit into another car, tree, railing, etc?				
<b>D</b>	Yes	🗆 No	Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?				
			What part of the vehicle was hit?				
			nd model of vehicle were you in? The other vehicle?				
	2. What kind of seat were you in? Bucket Bench Fabric Leather/Vinyl						
3.	3. Did the car have headrests?						
4.	4. Did you hit your head on the headrest?						
5.	5. Was the headrest positioned: below level with above the center of your head						
6.	6. Did your head hurt after the collision? 🛛 Yes 🖾 No Did your TMJ/jaw hurt after the collision? 🖵 Yes 🗅 No						
7.	7. How soon after the collision did you notice any pain?						
8.	B. Did the crash affect: dizziness memory concentration headaches balance in hightmares breathing						
			□ fatigue □ irritability □ ability to read □ ability to listen □ appetite □ nausea □ vision				
9.	Is the	ere anythi	ng else you want us to know?				
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## **PROVIDERS SEEN**

List <b>all</b> providers seen since injury occurred:					
. Clinic/Doctor/Hospital NameCity					
2. Clinic/Doctor/Hospital Name	City				
3. Clinic/Doctor/Hospital NameCity					
4. Clinic/Doctor/Hospital NameCity					
5. Clinic/Doctor/Hospital NameCity					
□ Yes □ No Do you have pictures of your vehicle? Where is it b	peing repaired?				
□ Yes □ No Do you have a copy of the police report?					
Name of your Attorney if you have one:					
Name of Your Car Insurance Co Your Health Ins. Co					
Name of the Other Divers car Insurance if Applicable					

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