INTEGRATIVE
Naturopathic Medical Centre

Vehicle Incident Assessment Form

Name:

Date of accident:

Date of first visit in the office regarding this accident:

Time and place of accident:

1) Were you using seat belts?

Head rests?

2) Was your body thrown around?

(Please specify which part of your body was struck and in which direction)

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3) Describe the sensation you felt:

Immediately after the impact:

One hour later:

That evening:

The next day:

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4) Have other symptoms appeared since the accident?

5) How long after the accident did they appear?

6) Were you taken to the hospital? Yes / No

7) What is your course of treatment with other Doctors, Physiotherapists, Chiropractors, medication, X-rays, etc.

8) What is your major complaint?

9) How long did it last?

10) Any other symptoms (nausea, headache, etc.)

11) How long did these last?

12) Did you experience?

- Tingling or numbness in the extremities?
- Dizziness?
- Fatigue?
- Other? _____

13) Describe the accident:

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