Auto Accident Form

Patient Name _____ Today's Date ____/_____/_____

Accident Location: (City & Streets)_____

Please describe to the best of your knowledge what happened during the accident: _____

_____

_____

_____

Please mark your involvement in the Auto Accident: □ Pedestrian □ Driver □ Passenger

What are your current symptoms? □ Pain □ Numbness □ Stiffness □ Weakness
Please mark if you experienced or are experiencing any of the following symptoms due to the auto accident:
□ Confused □ Disoriented □ Light headed □ Dizzy □ Nauseated □ Blurred Vision □ Ringing or buzzing in ears
□ Restless □ Irritable □ Sleeplessness □ Forgetfulness □ Difficulty with Memory □ Reduced Tolerance to heat or cold

Date of Accident ____/_____/_____ Accident Time: _____ AM/PM

Did the police come to the scene of the accident: YES NO *If yes, please provide a police report*

Accident Details
Patient was located: □ Driver □ Passenger- middle front □ Passenger- right front
□ Passenger- left rear □ Passenger- middle rear □ Passenger -right rear

Patient Vehicle Type: □ Compact □ Mid-size □ Full-Size □ SUV □ Pick-up □ Motorcycle
Second Vehicle Type: □ Compact □ Mid-size □ Full-Size □ SUV □ Pick-up □ Motorcycle
Third Vehicle Type: □ Compact □ Mid-size □ Full-Size □ SUV □ Pick-up □ Motorcycle

Road Conditions: □ Clear □ Dark □ Dry □ Foggy □ Icy □ Wet
Road Type: □ Asphalt □ Concrete □ Dirt □ Gravel

Were you aware the accident was going to occur? □ Yes □ No
Were you wearing a seatbelt? □ Yes □ No
Did your airbag deploy? □ Yes □ No
Does your car have a head rest? □ Yes □ No
What position was the head rest in? □ Up □ Middle □ Down

Patient's Head Position: □ Looking Straight Ahead □ Looking Up □ Looking Down
□ Left Level □ Left Up □ Left Down □ Right Level □ Right Up □ Right Down

Was your car braking? □ Yes □ No Was your car moving? □ Yes □ No
If yes, how fast? (mph) □ <5 □ 6-10 □ 11-15 □ 16-20 □ 21-30 □ 31-40 □ 41-50 □ 51-60 □ 61-70 □ >70

Was the second vehicle braking? □ Yes □ No Was the second vehicle moving? □ Yes □ No
If yes, how fast? (mph) □ <5 □ 6-10 □ 11-15 □ 16-20 □ 21-30 □ 31-40 □ 41-50 □ 51-60 □ 61-70 □ >70

Was the third vehicle braking? □ Yes □ No Was the third vehicle moving? □ Yes □ No
If yes, how fast? (mph) □ <5 □ 6-10 □ 11-15 □ 16-20 □ 21-30 □ 31-40 □ 41-50 □ 51-60 □ 61-70 □ >70

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Collision Details

First Impact: □ hit by other vehicle □ hit other vehicle □ hit by object □ hit object
Impact Location: □ front □ front-right □ front-left □ left □ right □ right-rear □ left-rear □ rear □ top

Second Impact: □ hit by other vehicle □ hit other vehicle □ hit by object □ hit object
Impact Location: □ front □ front-right □ front-left □ left □ right □ right-rear □ left-rear □ rear □ top

Collision Results

Body was thrown: □ Forward □ Backward □ Left □ Right □ Can't Remember

Head Hit: □ airbag □ front windshield □ rearview mirror □ steering wheel □ dashboard
□ back of the front seat □ side window/door □ another person's body □ headrest

Chest Hit: □ airbag □ steering wheel □ dashboard □ back of the front seat
□ side window/door □ another person's body

Shoulders Hit: □ shoulder harness □ side window/door □ back of front seat □ another person's body

Knees Hit: □ steering wheel □ dashboard □ back of the front seat
□ door panel □ center console □ another person's body

Hips Hit: □ steering wheel □ dashboard □ back of the front seat
□ door panel □ center console □ another person's body

Vehicle Damage

Patient Vehicle: □ totaled □ significant damage □ light damage □ no damage
Second Vehicle: □ totaled □ significant damage □ light damage □ no damage
Third Vehicle: □ totaled □ significant damage □ light damage □ no damage

Describe Damage:

_____

_____

Hospitalized

Were you hospitalized? □ Yes □ No. If yes, please answer the questions below.

When were you hospitalized? □ immediately □ later same day □ next day □ date _____

How were you transported to the hospital? □ ambulance □ life flight □ private transportation

What did the hospital recommend? □ no instructions □ see this clinic □ see DC
□ see own doctor □ see orthopedist □ see neurologist □ prescription medication
□ other: _____

Did you have any x-rays taken? □ Yes □ No
If yes, what areas? _____

Please describe any bodily injury that resulted from the accident: _____

_____