Automobile Crash History Form

Patient Name:_____ Today's Date: _____

Date of Crash: _____ Time of Crash: _____ AM/PM
City of Crash: _____ Street/Road of crash: _____

Make/Model of vehicle you were in: _____
Make/Model of other vehicle: __N/A _____
If no other vehicle, what did your vehicle hit?: _____

Were you: __Driver __Front passenger __ Rear passenger (R/L) __Other_____
Were you (at impact): __ Stopped __Decelerating __Accelerating __ Steady Speed
If moving, did the driver hit the brakes before impact? Y/N
If moving, what was estimated speed *at the moment of impact*: _____

Weather: __Nice __Rain __Windy __Snow __Sleet __Fog __Other: _____
Road Conditions: __ Clear __Wet __ Icy __ Snow __ Mud __Gravel __ Other: _____
Traffic: __ None __ Light __ Moderate __ Heavy

Wearing seatbelt?: Yes/No __N/A Did the seatbelts cinch/lock at impact? Yes/No __ N/A
Body position prior to impact: __ Good __ Forward __ Right __ Left __Twist R __Twist L
Head position prior to impact: __ Good __ Down __Up __Turned Right __ Turned Left
Hands on the wheel? Y/N: __ Right __ Left __ N/A Were you aware of impending crash? Y/N
Brace for Impact? Y/N: __Grip steering wheel __ Hit brakes __Other: _____

Describe what happened during the crash (how the vehicles hit one another): _____
_____
_____
_____

Did your seat recline at impact? Y/N __ N/A Did the seat break? Y/N __ N/A
Airbags deploy?: Y/N __ N/A Where did airbag hit you? _____

What happened to your car during impact? __ Accelerated forward __ Suddenly stop __ Nothing
__Spun right/left __ Pushed right/left __ Flipped end over end __Rolled side over side
Did your car strike anything after initial impact? Y/N: __Another car __Ditch __ Pole __Curb
__Building __ Sign __ Other:_____
Where was the impact(s) on your car?: _____
_____

Have you received a damage estimate yet?: Y/N If yes, estimate: _____
Damage to other vehicle: __ None __ Minimal __ Moderate __ Major
Is there a police report of this crash? Y/N

Do you remember what happened to you inside the vehicle during the crash? Y/N/Somewhat
__ Jolted back and forward __ Jolted side-to-side __Bounced up and down in seat
Did you strike anything inside the vehicle? Y/N __ Steering wheel __Dash __ Other: _____
Were you ejected from vehicle? Y/N If so, where did you land? _____
Did you lose consciousness? Y/N If yes, for how long? _____

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What symptoms did you have immediately after the crash (check all that apply)?
__None __Neck pain __Mid back pain __Low back pain __Chest pain __ Arm pain (R/L)
__Leg pain (R/L) __Head pain __Disoriented __Nausea __Dizzy __Blurred vision
__Other:_____
Of these symptoms, which remain? __All __None __Other:_____
_____

What bleeding cuts did you sustain? __None __Other: _____
_____
What bruises or abrasions did you sustain __None _Other: _____
_____
Where did you go after the crash?: __ER __Home __Work __Other: _____
How did you get there? __EMS __Drove self __Other: _____

Did you go the emergency department? Y/N Were you admitted overnight? Y/N
When did you go?: __Immediately after crash __Later that day/night __Next day __ Other: _____
Which hospital did you go to?: __Conway __Loris __Grand Strand __South Strand __Seacoast
__Georgetown __Marion __MUSC __Other: _____

Did the doctor examine you? Y/N Did you have x-rays? Y/N If so, what parts of you body?
__Neck __Mid back __Low Back __Chest __Other: _____
What special studies were done? __None __CT of (body region)_____
__MRI of (body region)_____ __EKG __Other: _____
Was lab work completed? Y/N __Blood __Urine __Other: _____

What medication was dispensed at the ER? __None __Other: _____
What medication was prescribed? __None __Other_____
Have you filled your prescription? Y/N If not, why? __Plan to __ Don't like to take medicine
__Can't afford the medicine __Other: _____
What instructions were given to you before you left? __Rest __Ice __Heat __ Massage
__Work excuse (how long):_____ __Other: _____

Have you returned to the ER? Y/N If yes, why? _____
Dates: _____ Tests performed: _____
Treatment: _____

Have you seen any other doctors other than the ER? Y/N
Dr. _____ Specialty: _____
Treatment: _____ Outcome: _____

Other: _____
_____

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List your complaints in order of most severe to least severe

1. Location of pain: _____
When did it begin? _____
What makes it worse?_____
What makes it better?_____
What does it feel like?_____
Where does it move to?_____
How severe on scale of 0-10 (10 is extreme)?_____
How often do you feel the pain?_____
Is it getting better, worse or staying the same?_____
Do you have any other symptoms associated with it? _____
_____

2. Location of pain: _____
When did it begin? _____
What makes it worse?_____
What makes it better?_____
What does it feel like?_____
Where does it move to?_____
How severe on scale of 0-10 (10 is extreme)?_____
How often do you feel the pain?_____
Is it getting better, worse or staying the same?_____
Do you have any other symptoms associated with it? _____
_____

3. Location of pain: _____
When did it begin? _____
What makes it worse?_____
What makes it better?_____
What does it feel like?_____
Where does it move to?_____
How severe on scale of 0-10 (10 is extreme)?_____
How often do you feel the pain?_____
Is it getting better, worse or staying the same?_____
Do you have any other symptoms associated with it? _____
_____

4. Location of pain: _____
When did it begin? _____
What makes it worse?_____
What makes it better?_____
What does it feel like?_____
Where does it move to?_____
How severe on scale of 0-10 (10 is extreme)?_____
How often do you feel the pain?_____
Is it getting better, worse or staying the same?_____
Do you have any other symptoms associated with it? _____
_____