Auto Accident Form

Patient Name _____ **Today's Date** ___/___/_____

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

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Date of Accident ___/___/_____ **Time Accident Occurred** _____:_____

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

Did your airbag deploy? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ 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 ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Accident Details:

Brief Description of Accident: _____

_____

_____

_____

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

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

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? _____

Insurance Information:

Accident reported to your auto or liability insurance company? Yes / No

Name of auto or liability insurance company: _____

Telephone number: _____

Claim number: _____

Attorney and Telephone: _____

Signature: _____ **Date:** _____

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