Auto Accident Form

Name _____ Today's Date ____/_____/_____ Date of Accident ____/_____/_____

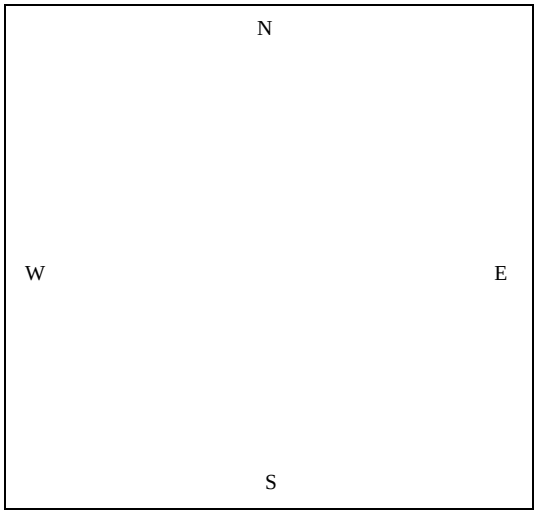
Describe briefly in your own words what happened _____

_____

_____

_____

Accident Diagram



History of Occurrence

☐ Pedestrian ☐ Driver ☐ Passenger- Middle Front ☐ Passenger- Right Front
☐ Passenger- Left Rear ☐ Passenger- Center Rear ☐ Passenger -Right Rear

If passenger, the vehicle was driven by: _____

Patient Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____
Year, make and model _____
Second Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____
Year, make and model _____
Third Vehicle Type
☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle ☐ Other _____
Year, make and model _____

Road Conditions
☐ Dry ☐ Icy ☐ Wet ☐ Clear ☐ Foggy ☐ Dark ☐ Other _____

Road Type
☐ Concrete ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other _____

Weather Conditions
□ Clear □ Cloudy □ Dark □ Foggy □ Icy □ Snowy

Were you aware the accident was going to occur? □ Yes □ No. Were you wearing a lap belt? □ Yes □ No

Did your airbag deploy? □ Yes □ No Were you wearing a shoulder belt? □ Yes □ No

Does your car have a head rest? □ Yes □ No

What position was the head rest in? Up □ Middle □ Down

Type of headrest: □ Integral □ Adjustable

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

Body position: □ Good □ Forward Lean □ Other _____

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

Was the seatback adjustment altered by the accident? □ Yes □ No

Was the seat broken? □ Yes □ No

Did you lose consciousness? □ Yes □ No If yes, how long? _____

Collision Details

First Impact: □ Hit By Another Vehicle □ Hit Another Vehicle □ Hit By An Object □ Hit An Object
(on the) □ Front □ Front-Right □ Front-Left □ Left □ Right □ Right-Rear □ Left-Rear □ Rear □ Top

Second Impact: □ Hit By Another Vehicle □ Hit Another Vehicle □ Hit By An Object □ Hit An Object
(on the) □ Front □ Front-Right □ Front-Left □ Left □ Right □ Right-Rear □ Left-Rear □ Rear □ Top

Collision Results

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

Head Hit: □ Airbag □ Another Person's Body □ Back Of Front Seat □ Dashboard
□ Front Windshield □ Rear-View Mirror □ Side Window/Door □ Steering Wheel
□ Windshield

Chest Hit: □ Another Person's Body □ Back Of Front Seat □ Dashboard □ Side Window/Door
□ Steering Wheel

Shoulders Hit: □ Another Person's Body □ Back Of Front Seat □ Shoulder Harness □ Side Window/Door

Knees Hit: □ Another Person's Body □ Back Of Front Seat □ Center Console □ Dashboard
□ Door Panel □ Steering Wheel

Hips Hit: ☐ Another Person's Body ☐ Back Of Front Seat ☐ Center Console ☐ Dashboard
☐ Door Panel ☐ Steering Wheel

Vehicle Damage AMOUNT

First 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 **$_____**

Were you taken to the hospital? ☐ Yes ☐ No If yes, please answer the questions in the paragraph below.

When were you taken to the hospital? ☐ Immediately ☐ Later The Same Day ☐ The Next Day ☐ Date _____

How were you transported to the hospital? ☐ Ambulance ☐ Flight for Life ☐ Private Transportation

What did the hospital recommend? ☐ No Instructions ☐ See This Clinic ☐ See DC ☐ See Own Doctor
☐ See Neurologist ☐ See Orthopedist ☐ Over The Counter Medication ☐ Prescription Medication
☐ Other _____

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

Were there police at the scene? ☐ Yes ☐ No Was there a police report? ☐ Yes ☐ No

After The Crash

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation
☐ Extremity pain ☐ Back pain ☐ Neck pain
Paresthesia(s): ☐ Burning ☐ Prickling ☐ Tingling ☐ Abnormal sensations
If yes, where? _____

When did symptoms first appear? ☐ Immediately(describe which symptoms)_____

How many hours/days/months after accident did symptoms appear? _____
Describe which symptoms _____

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