Auto Accident Information

Patient Name: ____

Date: ____________________

Date and time of accident: ___________________________ AM _____ PM ___

Were you the: Driver: _____ Front Passenger ______ Rear Passenger ___

Make and model of the vehicle you were occupying: ____________________________

Number of people in accident vehicle: __________

Did the police come to the accident site? Yes _____ No _____

Were there any witnesses? Yes _____ No______

Were you wearing a seatbelt? Yes _____ No ______

As this vehicle equipped with airbags? Yes ______ No ______

If yes, did it/they inflate? Yes ______ No _______

In relation to the base of your skull, where was the headset?

Above ____ Below ____ At the base of skull _____

What did your vehicle impact? Another Vehicle _____ Other ____

If other, please explain: ____

Did any part of your body strike anything in the vehicle? Yes ____ No _____

If yes, please describe: ____

Make and model of the other vehicle(s) involved? _________________________

Name of the location/street on which you were traveling? ___________________

In which direction were you headed? N ___ S ___ E ____ W ____

What was the approx. speed of your vehicle? ____________

Did the impact to your vehicle come from the:

Front ____ Rear _____ Right Side _____ Left Side _____ Other ______

During the impact, were you facing: Right _____ Left _____ Forward ______

Were you ______ aware or ______ surprised by the impact?

If the accident vehicle made impact with another vehicle…

Direction of other vehicle? N ____ S ____ E _____ W _____

Approximate speed of the other vehicle? ______________

In your own words, please describe the accident:

____
____
____
____

Please indicate your degree of comfort while performing the following activities:

Lying on back…..	____ Comfortable	____ Uncomfortable	____Painful
Lying on side…..	____ Comfortable	____ Uncomfortable	____ Painful
Lying on stomach…	____ Comfortable	____ Uncomfortable	____ Painful
Sitting…..	____ Comfortable	____ Uncomfortable	____ Painful
Standing….	____ Comfortable	____ Uncomfortable	____ Painful
Stretching….	____ Comfortable	____ Uncomfortable	____ Painful
Lovemaking…	____ Comfortable	____ Uncomfortable	____ Painful
Walking…	____ Comfortable	____ Uncomfortable	____ Painful
Running…	____ Comfortable	____ Uncomfortable	____ Painful
Sports…	____ Comfortable	____ Uncomfortable	____ Painful
Working…	____ Comfortable	____ Uncomfortable	____ Painful
Lifting….	____ Comfortable	____ Uncomfortable	____ Painful
Bending….	____ Comfortable	____ Uncomfortable	____ Painful
Kneeling…	____ Comfortable	____ Uncomfortable	____ Painful
Pulling…	____ Comfortable	____ Uncomfortable	____ Painful
Reaching…	____ Comfortable	____ Uncomfortable	____ Painful

Have you retained an attorney: ____ Yes ____ No

If yes, whom? ____

His/Her phone #: ____

Recovery

How many hours are in your normal workday? ________

Please indicate your daily job duties and any activities that you may be occasionally asked to perform:

_____ Standing	_____ Twisting
_____ Sitting	_____ Crawling
_____ Walking	_____ Bending
_____ Lifting	_____ Operating Equipment
_____ Driving	_____ Work with arms above head
	Other: ___________________________

What positions can you work in with minimum physical effort, and for how long?

____ N/A ________

Prior to the injury were you capable of working on an equal basis with others your age?

____ Yes ____ No _____ N/A

Do you work with others who can help you with any heavy lifting?

____ Yes ____ No _____ N/A

While in recovery, is there any light duty work you could request?

____ Yes ____ No _____ N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If

account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any charges to the information I have provided.

Your auto insurance company's name (even if another party is at fault):
_____________________________ Claim # _______________________

Name of auto insurance company of the party that hit you:

_____________________________ Claim # ________________________

Signature _____________________________________ Date ____/____/____

___ Adult Patient   ____ Parent or Guardian   ____ Spouse