springfield wellnesscenter

Automobile Accident Information Form

Patient Name: _____ **Today's Date:** _____

Please circle your answer to the questions below

1. What was your involvement in the Auto Accident: Pedestrian Driver Passenger

2. What are your current symptoms? Pain Numbness Stiffness Weakness

3. Date of the Accident: _____/_____/_____

4. **Where were you located:** Driver Passenger-Right Front Passenger-Middle Front
Passenger-Left Rear Passenger-Middle Rear Passenger-Right Rear

5. Were you alone in the car? Yes / No **6. If no how many people were in the car?** _____

7. Patient Vehicle Type: Compact Mid-Size Full-Size SUV Truck Motorcycle

8. Second Vehicle Type: Compact Mid-Size Full-Size SUV Truck Motorcycle

9. Third Vehicle Type: Compact Mid-Size Full-Size SUV Truck Motorcycle

10. Road Conditions: Clear Dark Dry Foggy Icy Wet

11. Road Type: Asphalt Concrete Dirt Gravel Grass

12. Were you aware the accident was going to occur? Yes / No **13. Did you brace for impact?** Yes / No

14. Were you wearing a seatbelt? Yes / No **15. Did you lose conciousness?** Yes / No

16. Did your airbag deploy? Yes / No **17. When did pain start:** Right away / Delayed Onset

18. Does your car have a headrest? Yes / No **19. What position was it in?** Up Middle Down

20. **Patient's head postion:** Looking Stright Ahead Left Level Left Up Left Down
Right Level Right Up Right Down Looking Up Looking Down

21. **Was your car braking?** Yes / No **22. Was your car moving?** Yes / No

How fast? <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

23. Was the second vehicle braking? Yes / No **24. Was the second car moving?** Yes / No

How fast? <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

25. Was the third vehicle braking? Yes / No **26. Was the third car moving?** Yes / No

How fast? <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

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Collision Details:

27. First Impact: Hit by other vehicle | Hit other vehicle | Hit by object | Hit object

28. Impact Location: Front | Front-Right | Front-Left | Right | Left | Right-Rear | Left-Rear | Rear | Top

29. Second Impact: Hit by other vehicle | Hit other vehicle | Hit by object | Hit object

30. Impact Location: Front | Front-Right | Front-Left | Right | Right | Right-Rear | Left-Rear | Rear | Top

31. Body was thrown: Forward | Backward | Left | Right | Can't Remember

32. Head Hit: Air bag | Front windshiled | Rearview Mirror | Steering WheelDashboard | Back of seat | Side window/door | Another person | Headrest

33. Chest Hit: Airbag | Steering Wheel | Dashboard | Back of the front seat | Side window/door | Another person's body

34. Shoulders Hit: Shoulder Harness | Side window/door | Back of seat | Another person's body

35. Knees Hit: Steering wheel | Dashboard | Back of the front seat | Door panel | Center console | Another person's body

36. Hips Hit: Steering wheel | Dashboard | Back of the front seat | Door panel | Center console | Another person's body

Damage to vehicle:

37. Patient's Vehicle: Totaled | Significant Damage | Light damage | No damage

38. Second Vehicle: Totaled | Significant Damage | Light damage | No damage

39. Third Vehicle: Totaled | Significant Damage | Light damage | No damage

40. Were you hospitalized? Yes / No **If yes, please answer the following questions below.**

41. When were you hospitalized? Immediately | Later same day | Next day | Date: _____

42. How were you transported? Ambulance | Life Flight | Private Transportation

43. What did the hospital recommend? No instructions | See this clinic | See a chiropractor | See MD | See orthopedist | See neurologist | Prescription Medication | Other: _____

44. Were X-rays taken? Yes / No If yes, what areas? _____

I certify that the above information is correct to the best of my knowledge.

Signature: _____

Date: _____