AUTO ACCIDENT INFORMATION

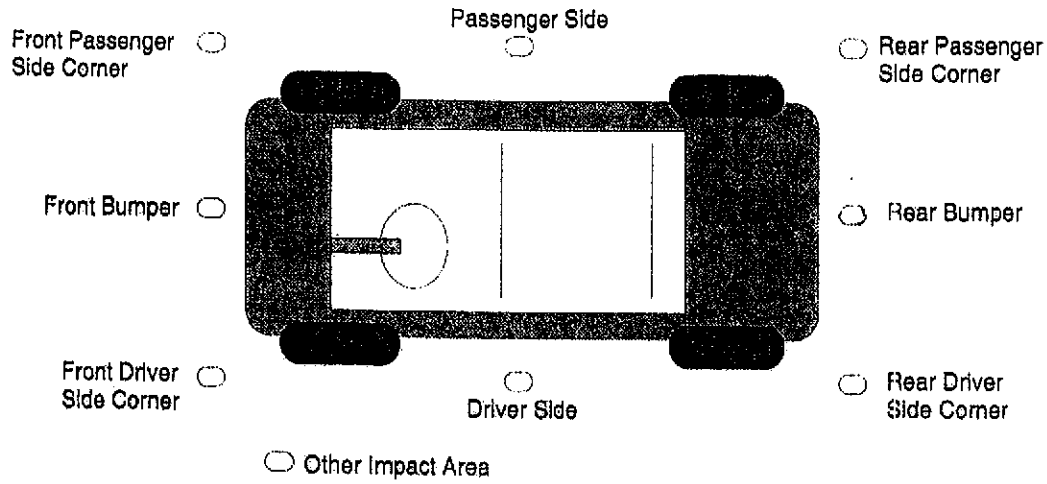
Patient's Name_____ Date of Birth:_____ Today's Date:_____
Address:_____ Date of Accident:_____
City:_____ State:_____ Zip:_____ Time of Accident:_____
Home #:_____ Work#:_____

Please describe how the accident happened
Just before the accident:

My vehicle was: ☐ at a traffic light ☐ at a stop sign going straight ☐ making a right left turn
☐ stopped for traffic ahead ☐ entering traffic from a side street/driveway
traveling at _____mph ☐ Other_____

Other vehicle: ☐ hit me in the rear ☐ ran a light ☐ making a ☐ right ☐ left turn
☐ entering traffic from a side street/driveway ☐ ran across my lane
other_____

Mark with "X" where you were sitting - and then fill in the bubble where your vehicle was hit:



☐ I was the driver Involved in a ☐ auto ☐ other type of accident in city_____ state_____
☐ I was the passenger sitting in the: ☐ middle front seat ☐ right front seat ☐ left rear seat
☐ middle rear seat ☐ right rear seat
Involved in a ☐ auto ☐ other type of accident in city_____ state_____

☐ I was a pedestrian: ☐ standing ☐ sitting ☐ riding a bike ☐ walking ☐ other

☐ I was traveling in a vehicle: Year: _____ Make:_____ Model:_____
Transmission type: ☐ manual ☐ automatic

Road conditions were: ☐ dry ☐ damp ☐ wet ☐ dark ☐ clear ☐ raining

Visibility was: ☐ poor ☐ fair ☐ good

The road was made of: ☐ concrete ☐ asphalt ☐ gravel ☐ dirt ☐ other_____
Did your car have a head rest: ☐ yes ☐ no
If your car had a head rest, what position was it in: ☐ up ☐ middle ☐ down

Were you: Wearing your seat belt? ☐ yes ☐ no Wearing your harness? ☐ yes ☐ no
Did your air bag deploy? ☐ yes ☐ no ☐ n/a
Head position: At the time of the accident my head was looking:
☐ straight ahead ☐ to the right ☐ to the left ☐up ☐ down ☐other_____

Brakes: Were your brakes applied at the time of impact? ☐ yes ☐ no

Elbows: My ☐ left ☐ right ☐ was on the arm rest. Other_____
Hands: ☐ both ☐ right ☐ left hand was on the steering wheel.
☐ Can't remember ☐ other_____

Were you aware of the impending collision before it happened:? ☐ yes ☐ no
Did you tighten your body and brace for the collision? ☐ yes ☐ no
Your hands, as a result of the impact:
☐ grabbed the steering wheel tightly ☐ were forced off the steering wheel / stick shift
☐ other_____

As a result of the impact, your body was thrown: ☐ forward ☐ backward ☐ right ☐ left
☐ turned to the right (clockwise) ☐ turned to the left (counter clockwise) ☐ can't remember

As a result of the impact, your head hit the: ☐ front windshield ☐ rearview mirror
☐ steering wheel ☐ back of the seat ahead of me ☐ side driver / passenger ☐ inside window / door
☐ another person's body ☐ back of my head hit the headrest ☐ other_____
☐ nothing

As a result of the impact, your shoulders were: ☐ impacted with the inside of the door / car
☐ pressed firmly against the shoulder harness ☐ other_____

As a result of the collision, what other parts of your body struck the inside of the vehicle:
☐ ankles ☐ elbows ☐ face ☐ chest ☐ thighs ☐ forearms
☐ other_____ ☐ other_____

Did another car hit you: ☐ yes ☐ no
Point of impact: ☐ head on ☐ rear end ☐ left front ☐ left rear ☐ right front ☐ right rear

Did your vehicle strike or impact with a second object after the first impact? ☐ yes ☐ no

Did your vehicle strike a ☐ Car ☐ truck ☐ road/median ☐ building ☐ other:_____

Were you wearing your glasses at the time of the accident? ☐ none ☐ yes ☐ no

If yes, were your glasses still on following the accident? ☐yes ☐ no

Did you lose consciousness as a result of the accident? ☐ yes ☐ no
If yes, how long were you unconscious: _____
Damage to my vehicle was ☐ mild ☐ moderate ☐ severe
Damage to other vehicle was ☐ mild ☐ moderate ☐ severe
Estimated cost to repair your car: $_____
After the accident the car was: ☐ totaled ☐ drivable ☐ not drivable
At the time of the accident, how many people were in the car with you: _____
Names of the occupants:
1._____
2._____
3._____
4._____
5._____
6._____

Were the other occupants injured? ☐ yes ☐ no If yes, explain:_____
Were the police called to the scene? ☐ yes ☐ no
Was a police report written? ☐ yes ☐ no
Was a ticket given to you? ☐ yes ☐ no

Was a ticket given to the other driver? ☐ yes ☐no
As a result of the accident I felt my symptoms:
☐ Immediately ☐ within one hour ☐ within 6 hours ☐ during the night
☐ Next morning ☐ Next day ☐ other_____
As a result of the accident I felt:
☐ headaches ☐ upper back pain ☐ chest pain/soreness ☐ wrist / elbow pain / soreness
☐ neck pain ☐ low back pain ☐ stomach pain/soreness ☐ knee/ankle pain/soreness
☐ shoulder pain ☐ numb/tingling/burning arms ☐ numb/tingling/burning legs
☐ loss of bowel / bladder control list all other symptoms_____
Please list location of any cuts or bruises if applicable:_____
Did you go to the hospital? ☐yes ☐ no
If no, where did you go? ☐ home ☐ work ☐ your primary Doctor

If yes: ☐ immediately ☐ next day ☐ later in same ☐ other_____
Did you go to the hospital by ☐ ambulance ☐ private transportation ☐ drove self
☐ someone else drove

Name of hospital_____City_____

Were you admitted to hospital? ☐ yes ☐ no
If yes, how long was your stay:_____
Hospital treatment: ☐ Exams ☐ x-rays ☐ lab work

What follow-up recommendations were made? ☐ see your own doctor ☐ see orthopedist / neurologist
☐ physical therapist ☐ braces/collars ☐ released
☐ prescription: what types_____

Please list all doctors you have seen since the accident

	Doctor's Name	First Visit Date	Treatment	City	
1.					Released ☐ yes ☐ no
2.					Released ☐ yes ☐ no
3.					Released ☐ yes ☐ no
4.					Released ☐ yes ☐ no

Are you working now? ☐ yes ☐ no
Were you employed at the time of this accident? ☐ yes ☐ no
Type of work you do-- Title:_____

Are you currently working with restrictions? ☐ yes ☐ no
Has the doctor placed you on: ☐ total disability ☐ partial disability ☐ does not apply
Please list work restrictions if any:_____

Please list any special tests ordered by the hospital or doctor:_____

Since the accident do you feel: ☐ worse ☐ no improvement ☐ better ☐ other_____

% Of Improvement 1 2 3 4 5 6 7 8 9 10 please circle with 10 being the very best

Pain Scale 1-10 with 10 being the worst: 1 2 3 4 5 6 7 8 9 10 please circle

ADDITIONAL NOTES:

_____
_____
_____
_____
_____
_____
_____
_____