Auto Accident Form

Patient Name ____ Today's Date ____/_____/______

Accident Location: (City & Streets)____

Please describe to the best of your knowledge what happened during the accident: _________________________________

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

What are your current symptoms? Pain Numbness Stiffness Weakness
Please mark if you experienced or are experiencing any of the following symptoms due to the auto accident:
Confused Disoriented Light headed Dizzy Nauseated Blurred Vision Ringing or buzzing in ears
Restless Irritable Sleeplessness Forgetfulness Difficulty with Memory Reduced Tolerance to heat or cold

Date of Accident ____/_____/_____ Accident Time: _____________________ AM/PM

Did the police come to the scene of the accident: YES NO *If yes, please provide a police report*

Accident Details
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
Were you wearing a seatbelt? Yes No
Did your airbag deploy? 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 Looking Up Looking Down
Left Level Left Up Left Down Right Level Right Up Right Down

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

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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

Describe Damage:
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____

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? ____

Please describe any bodily injury that resulted from the accident: ______________________________

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