Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other_____

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
☐ Mild ☐ Moderate
☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact
☐ Head-On ☐ Left Front ☐ Right Front
☐ Rear-End ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming: Yes☐☐ No
Were you braced for the impact? Yes☐☐ No
Did you have a seat belt on? Yes☐☐ No
Did you have a shoulder harness on? Yes☐☐ No

Does your vehicle have headrests? Yes☐☐ No
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? Yes☐☐ No Did passenger side airbags deploy? Yes☐☐ No Did side airbags deploy? Yes☐☐ No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? Yes☐☐ No
If yes, describe:_____
Did you lose consciousness during the injury? Yes☐☐ No
If yes, for how long? _____
Your vehicle's estimated damage?_____
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled
Did police show up at the scene? Yes☐☐ No
Was an accident report filled out? Yes☐☐ No

10. After the accident:

Check off your symptoms right after and a few days following:
☐ Headache ☐ Dizziness ☐ Mid back pain ☐ Cold hands
☐ Neck pain ☐ Nausea ☐ Low back pain ☐ Cold feet
☐ Neck stiffness ☐ Confusion ☐ Nervousness ☐ Diarrhea
☐ Fainting ☐ Fatigue ☐ Loss of taste ☐ Depression
☐ Ringing in ears ☐ Tension ☐ Toe numbness ☐ Anxious
☐ Loss of smell ☐ Irritability ☐ Constipation ☐ Chest Pain
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were X-rays done? Yes☐☐ No **Was lab work done?** Yes☐☐ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed:_____
Treatments: ☐ Cervical Collar ☐ Ice **Other:** _____
Medications:_____
Follow-up instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office
1. Dr._____ First visit date: ___/___/___
Specialty:_____ X-rays done? Yes☐☐ No
Types of treatments received:_____
How many treatments received? ____ Currently treating? Yes☐☐ No
Did treatments benefit you? Yes☐☐ No
Last visit date: ___/___/___
2. Dr._____ First visit date: ___/___/___
Types of treatments received:_____
How many treatments received? ____ Currently treating: Yes☐☐ No
Did treatments benefit you? Yes☐☐ No
Last visit date: ___/___/___

Patient Sign & Date:_____ **Date:**_____