

Auto Accident Form

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

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

What are your current symptoms? _____ Pain _____ Numbness _____ Stiffness _____ Weakness

Date of Accident ____/____/____

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	Left Level	Left Up	Left Down
	Right Level	Right Down	Looking Up	Looking Down

Accident Details

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

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

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?

see own doctor	see orthopedist	no instructions	see this clinic	see DC
other: _____		see neurologist	prescription medication	

Did you have any xrays taken? Yes No

If yes, what areas? _____