Auto Accident Information

Patient's Name_____ **Today's Date**_____
Date of Accident:_____ **Time of Accident:**_____

Please Describe How the Accident Happened (include just before the accident also):

_____
_____
_____

My vehicle was:

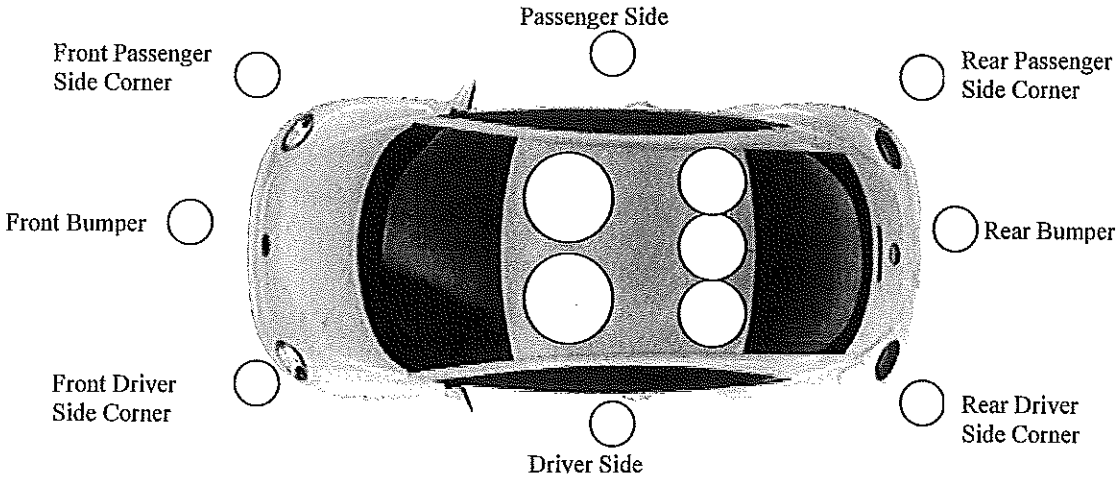
☐ **At a Traffic Light** ☐ **At a stop sign going straight** ☐ **Making a Right/Left Turn**
☐ **Entering Traffic from a side street/Driveway** ☐ **Other: (Explain)**

I was traveling at ___ MPH **The other vehicle was traveling at ___ MPH**

The 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: (Explain)**

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



I was the Driver/Passenger involved in the accident in (City) _____ **(State)**_____
I was sitting in the: ☐ **Middle Front Seat** ☐ **Right Front Seat** ☐ **Left Rear Seat**
☐ **Middle Rear Seat** ☐ **Right Rear Seat**
I was a pedestrian in an accident in (City) _____ **(State)**_____

I was a pedestrian: ☐ **Standing** ☐ **Sitting** ☐ **Riding a bike** ☐ **Walking** ☐ **Other**

Were you admitted: ☐ Yes ☐ No **If Yes, How long did you stay:** _____

What treatments did you receive at the hospital: ☐ Exam ☐ X-Ray ☐ MRI ☐ CT ☐ Lab Work

What follow up recommendations were made: ☐ See your own Dr. ☐ See orthopedist ☐ See Neurologist ☐ Physical Therapist ☐ Braces/Collars ☐ Released

☐ **Prescriptions: What types:** _____

List any special test taken at the hospital: _____

Please list all the Doctors you have seen since the accident:

Doctor Name	First Visit Date	Treatment	City	Released
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Are you working now: ☐ Yes ☐ No

Were you employed at the time of the accident: ☐ Yes ☐ No

Type of work you do: _____

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: _____

_____

Since the accident you feel: ☐ Better ☐ Worse ☐ No Change ☐ Other _____

% of improvement: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Pain Scale: 1=No pain 10=Worst pain ever 1 2 3 4 5 6 7 8 9 10

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Did your vehicle strike another: ☐ Car ☐ Truck ☐ Road/Median ☐ Building ☐ Other

Were you wearing your glasses at the time of the accident: ☐ 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 your unconsciousness: _____

Damage to my vehicle was: ☐ Mild ☐ Moderate ☐ Severe Is your vehicle drivable: ☐ Yes ☐ No

Damage to the other vehicle: ☐ Mild ☐ Moderate ☐ Severe Was the other car drivable: ☐ Yes ☐ No

Estimated cost to repair your car: _____

At the time of the accident, how many people were in the car with you: _____

Names of the occupants:

Were the other occupants injured: ☐ Yes ☐ No Were the police called: ☐ Yes ☐ No

Was a police report taken: ☐ 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 the 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/Angle Pain / Soreness
☐ Shoulder Pain	☐ Numb/Tingling/Burning Arms	☐ Numb/Tingling/Burning Legs	☐ Loss of Bowel/Bladder

Other areas of pain include: _____

List the location of any other cuts or bruises as a result of the accident:

_____

Did you go to the hospital: ☐ Yes ☐ No If No, Where did you go:_____

If Yes, When: ☐ Immediately ☐ Next Day ☐ Later in same day ☐ Other_____

How did you get to the hospital: ☐ Ambulance ☐ Private Transportation

☐ Drove yourself ☐ Someone else Drove

Name of the Hospital:_____ City: _____

Auto Accident Information

The vehicle I was traveling in was: Year_____ Make _____ Model_____

The other vehicle in the accident was: Year_____ Make _____ Model_____

Your transmission was: ☐ 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 seatbelt: ☐ Yes ☐ No Wearing your harness: ☐ Yes ☐ No

Did your airbag deploy: ☐ Yes ☐ No

At the time of the accident my head was looking:

☐ Left ☐ Right ☐ Straight ☐ Down ☐ Up ☐Other_____

Were your brakes applied at the time of the impact: ☐ Yes ☐ No

My elbows were: ☐ Left ☐ Right ☐ On the arm rest ☐ Other_____

My hands were: ☐ Left ☐ Right ☐ Both ☐ On the steering wheel ☐ 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 (counterclockwise) ☐ 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 persons 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:_____

_____

Did another car hit you: ☐ Yes ☐ No

Point of impact was: ☐ 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