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

What type of seatbelt were you wearing? □ Lap Belt Only □ Lap Belt + Shoulder Harness

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 Up □ 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? ☐ no instructions ☐ see this clinic ☐ see DC
☐ see own doctor ☐ see orthopedist ☐ see neurologist ☐ prescription medication
☐ other: _____

Did you have any xrays taken? ☐ Yes ☐ No
If yes, what areas? _____