

## 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

Weather Conditions    Clear                      Cloudy                      Dark                      Foggy    Icy                      Snowy

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 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***

<b>First Impact:</b>	hit by other vehicle	hit other vehicle	hit by object	hit object
<b>Impact Location:</b>	front	front-right	front-left	left
right	right-rear	left-rear	rear	top
<b>Second Impact:</b>	hit by other vehicle	hit other vehicle	hit by object	hit object
<b>Impact Location:</b>	front	front-right	front-left	left
right	right-rear	left-rear	rear	top

***Collision Results***

<b>Body was thrown:</b>	Forward	Backward	Left	Right	Can't Remember
<b>Head Hit:</b>	airbag	front windshield	rearview mirror	steering wheel	
dashboard	back of the front seat	side window/door	another person's body	headrest	
<b>Chest Hit:</b>	airbag	steering wheel	dashboard	back of the front seat	
	side window/door	another person's body			
<b>Shoulders Hit:</b>	shoulder harness	side window/door	back of front seat	another person's body	
<b>Knees Hit:</b>	steering wheel	dashboard	back of the front seat		
	door panel	center console	another person's body		
<b>Hips Hit:</b>	steering wheel	dashboard	back of the front seat		
	door panel	center console	another person's body		

***Vehicle Damage***

<b>Patient Vehicle:</b>	totaled	significant damage	light damage	no damage
<b>Second Vehicle:</b>	totaled	significant damage	light damage	no damage
<b>Third Vehicle:</b>	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? \_\_\_\_\_

