

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:

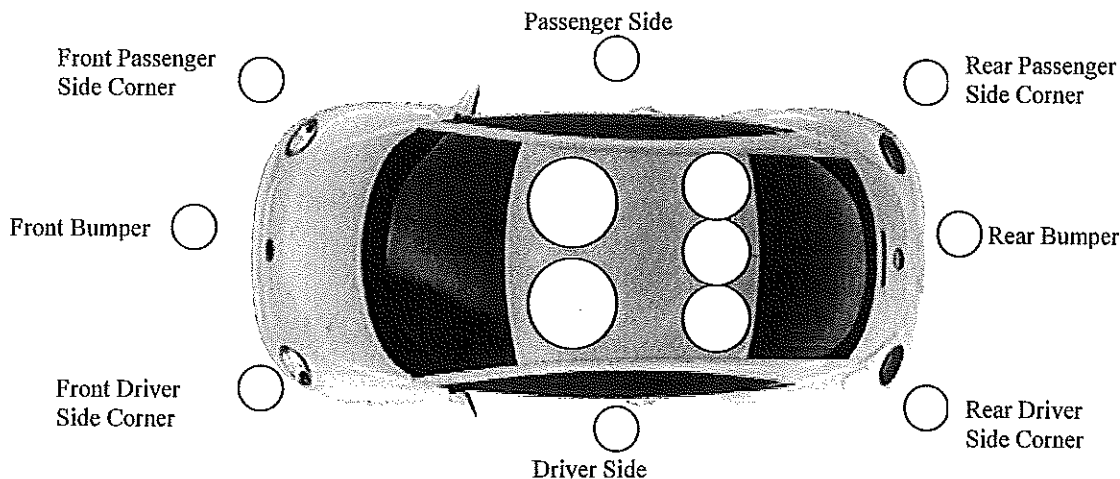
- | | | |
|---|--|---|
| <input type="checkbox"/> At a Traffic Light | <input type="checkbox"/> At a stop sign going straight | <input type="checkbox"/> Making a Right/Left Turn |
| <input type="checkbox"/> Entering Traffic from a side street/Driveway | <input type="checkbox"/> Other: (Explain) | |

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

The Other Vehicle:

- | | | |
|---|---|---|
| <input type="checkbox"/> Hit me in the rear | <input type="checkbox"/> Ran a light | <input type="checkbox"/> Making a Right/Left Turn |
| <input type="checkbox"/> Entering Traffic from a side street/Driveway | <input type="checkbox"/> Ran across my lane | <input type="checkbox"/> 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
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> 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 Side Driver /
ahead of me Passenger

Inside window / Another persons Back of my head Other Nothing
Door body hit the headrest

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