

# 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 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?** \_\_\_\_\_