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? _____