Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

☩ Car ☩ Station Wagon
☩ Van ☩ Pickup Truck
☩ Large Truck ☩ Bus
Other_____

2. Your position in vehicle

☩ Driver ☩ Front Passenger
☩ Left Rear Passenger
☩ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

☩ Stopped at intersection ☩ Stopped in traffic ☩ Stopped at light
☩ Making a right turn ☩ Making a left turn ☩ Parking
☩ Proceeding along ☩ Slowing down ☩ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
☩ Mild ☩ Moderate
☩ Totaled

5. Details of Accident

Visibility at time of accident
☩ Poor ☩ Fair ☩ Good

Who hit who/what?
☩ You hit other vehicle
☩ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
☩ Icy ☩ Wet ☩ Sandy ☩ Dark ☩ Clean and dry

Point of impact
☩ Head-On ☩ Left Front ☩ Right Front
☩ Read-End ☩ Left Rear ☩ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes☩ ☩ No**
Were you braced for the impact? **Yes☩ ☩ No**
Did you have a seat belt on? **Yes☩ ☩ No**
Did you have a shoulder harness on? **Yes☩ ☩ No**

Does your vehicle have headrests? Yes☩ ☩ No
What was the position of your headrest at the time of the impact?
☩ Even with top of head ☩ Even with bottom of head ☩ Middle of neck
What was the direction of your head at the time of the impact?
☩ Facing straight forward ☩ Turned to the right ☩ Turned to the left

Did driver side air bags deploy? **Yes☩ ☩ No** Did passenger side airbags deploy? **Yes☩ ☩ No** Did side airbags deploy? **Yes☩ ☩ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes☩ ☩ No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes☩ ☩ No**
If yes, for how long?_____
Your vehicle's estimated damage?_____
Damage to their vehicle: ☩ Mild ☩ Moderate ☩ Totaled
Did police show up at the scene? **Yes☩ ☩ No**
Was an accident report filled out? **Yes☩ ☩ No**

10. After the accident:

Check off your symptoms right after and a few days following:

☩ Headache	☩ Dizziness	☩ Mid back pain	☩ Cold hands
☩ Neck pain	☩ Nausea	☩ Low back pain	☩ Cold feet
☩ Neck stiffnes	☩ Confusion	☩ Nervousness	☩ Diarrhea
☩ Fainting	☩ Fatigue	☩ Loss of taste	☩ Depression
☩ Ringing in ears	☩ Tension	☩ Toe numbness	☩ Anxious
☩ Loss of smell	☩ Irritability	☩ Constipation	☩ Chest Pain
☩ Pain behind eyes	☩ Shortness of breath	☩ Sleeping problems	

Others:_____

11. Emergency Room?

Where did you go after the accident?
☩ Home ☩ Work ☩ Hospital ER ☩ Private Doctor
How did you get there?
☩ Drove self ☩ Somebody else ☩ Ambulance ☩ Police
Were X-rays done? Yes ☩ ☩ No **Was lab work done?** Yes ☩ ☩ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed:_____
Treatments: ☩ Cervical Collar ☩ Ice **Other:**_____
Medications:_____
Follow-up instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ___/___/___
Specialty:_____ X-rays done? **Yes☩ ☩ No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes☩ ☩ No**
Did treatments benefit you? **Yes☩ ☩ No**
Last visit date: ___/___/___
2. Dr. _____ First visit date: ___/___/___
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes☩ ☩ No**
Did treatments benefit you? **Yes☩ ☩ No**
Last visit date: ___/___/___