

Auto Accident Form

Patient Name _____ Today's Date ____/____/____

Date of Accident ____/____/____

Have you filed a report with your insurance? Yes No

Carrier: _____ Policy # _____

Carriers Phone #: (____) _____ - _____ Adjuster: _____ Claim #: _____

Have you retained an attorney to represent you in this case? Yes No

If yes, who? _____ Phone number of attorney: (____) _____ - _____

Please mark your involvement in the Auto Accident: Pedestrian Driver Passenger

What are your current symptoms? Pain Numbness Stiffness Weakness

Did you have any pain before the accident? Yes No

If so list areas of complaint before the accident? _____

Were you knocked unconscious? Yes No

Describe in your own words what happened during the 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 Tractor Trailer

Second Vehicle Type: Compact Mid-size Full-Size SUV Pick-up
 Motorcycle Tractor Trailer

Where there more vehicle involved? Yes No Describe: _____

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

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

Did you go to the hospital? Yes No If yes, please answer the questions below.

Were you hospitalized? Yes No

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? _____

I hereby state that the information provided by me is accurate and whole.

Print Name: _____ Patient's Signature: _____ Date: _____