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:_____________