Auto Accident Form

Patient Name				1	oday's Date	//	
Please mark your inv	olvement in the	e Auto Acc	ident:	□ Pedestri	an □ Drive	er 🗆 Passe	enger
What are your curren	nt symptoms?	□ Pain □	Numbness	□ Stiffness	s □ Wea	kness	
Date of Accident							
Patient was located:	□ Driver□ Passenger-		☐ Passenger- m☐ Passenger- m			enger- right fro enger -right re	
Patient Vehicle Type:	: □ Compact	☐ Mid-size	☐ Full-Size	□ SUV	☐ Pick-up	□ Motorcyc	le
Second Vehicle Type:	□ Compact	☐ Mid-size	□ Full-Size	□ SUV	□ Pick-up	□ Motorcyc	ele
Third Vehicle Type:	□ Compact	☐ Mid-size	□ Full-Size	□ SUV	□ Pick-up	□ Motorcyc	le
Road Conditions:	□ Clear	□ Dark	□ Dry		Foggy	□ Icy	□ Wet
Road Type:	☐ Asphalt	□ Concre	ete 🗆 Dirt		Gravel		
Were you aware the a	accident was go	oing to occu	ır? 🗆 Yes 🗆	No			
Were you wearing a s	seatbelt?	□ Yes □] No				
Did your airbag deplo	oy? □	Yes □ No					
Does your car have a	head rest? □	Yes □ No					
What position was the	e head rest in?	□ Up	☐ Middle	□ Down			
Patient's Head Position Right Level	on: Looking Right Up	_	ead □ Left Le □ Right I		Left Up Looking Up	☐ Left Down☐ Looking D	
Accident Details Was your car braking If yes, how fast? (mph)		□ No □ 11-15 □			ving?□ Yes □ 41-50 □ 5		□ >70
Was the second vehic If yes, how fast? (mph)	_				ehicle movin □ 41-50 □ 3	_	□ No
Was the third vehicle If yes, how fast? (mph)	0	Yes □ N 11-15 □ 1			nicle moving 41-50 🏻 51-6		□ No >70
Collision Details First Impact: Impact Location: □ right	□ hit by other□ front□ right-rear		☐ hit other vehi ☐ front-right ☐ left-rear		t by object ont-left ar	□ hit object□ left□ top	

Second Impact Impact Locatio		□ hit by other v□ front□ right-rear		□ hit other vehi□ front-right□ left-rear	cle	□ hit by object□ front-left□ rear		hit object left top				
Collision Resu Body was thro		□ Forward	□ Backv	vard □ Lef	t	□ Right		Can't Remember				
Head Hit: ☐ dashboard	□ airba □ back	g of the front seat		windshield vindow/door		earview mirror another person's b		steering wheel headrest				
Chest Hit:	□ airba □ side v	g vindow/door		ng wheel er person's body	_	lashboard		back of the front seat				
Shoulders Hit:	□ shou	lder harness	□ side v	vindow/door	□ b	ack of front seat		another person's body				
Knees Hit:	□ steeri	ing wheel panel	□ dashb	ooard r console		oack of the front so nother person's b						
Hips Hit:	□ steeri □ door	ng wheel panel	□ dashb	ooard r console		oack of the front so nother person's b						
Vehicle Dama	ıge											
Patient Vehicle	e:	\Box totaled	_	ficant damage		light damage		no damage				
Second Vehicle		□ totaled		ficant damage		light damage		no damage				
Third Vehicle:		□ totaled	⊔ signi.	ficant damage	Ц	light damage	Ц	no damage				
Hospitalized Were you hospitalized? \square Yes \square No. If yes, please answer the questions below.												
When were you	u hospit	alized? 🗆 imm	nediately	□ later same	day	□ next day	□ da	te				
How were you	transpo	rted to the hos	pital?	□ ambulance	;	☐ life flight	□ pr	ivate transportation				
What did the hospital recommend? □ no □ see own doctor □ see orthopedist □ see □ other: □												
Did you have a If yes, what are		s taken?	□ Yes	□ No								