

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
 Rear-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

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 stiffness Confusion Nervousness Depression
 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: ____/____/____