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**
Was your shoulder harness on? **Yes❑ ❑No**
Did driver side airbag deploy? **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 passenger side airbag deploy? **Yes❑ ❑No** Side airbags? **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 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 following the accident:

❑Headache	❑Dizziness	❑Mid back pain	❑Cold hands
❑Neck pain	❑Nausea	❑Low back pain	❑Cold feet
❑Neck stiffness	❑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?
❑Self ❑Somebody else ❑Ambulance. ❑Police
X-rays done? Yes❑❑No Lab work? 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 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: ____/____/____