



Auto Accident Form

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

Date of Accident ____/____/____

Please mark your involvement in the Auto Accident: Pedestrian Driver Passenger
What are your current symptoms? Pain Numbness Stiffness Weakness

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

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

Hips 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

Were you hospitalized? Yes No (If yes, please answer the questions below.)

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 x-rays taken? Yes No

If yes, what areas? _____

Your Auto Insurance Company: _____

Claim #: _____

Insurance Contact Phone Number: _____