

Date of Accident: _____

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 <input type="checkbox"/> Car <input type="checkbox"/> Station Wagon <input type="checkbox"/> Van <input type="checkbox"/> Pickup Truck <input type="checkbox"/> Large Truck <input type="checkbox"/> Bus Other _____	2. Your position in vehicle <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Left Rear Passenger <input type="checkbox"/> Right Rear Passenger Other _____	3. What was your vehicle doing at the time of the accident? <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Stopped at light <input type="checkbox"/> Making a right turn <input type="checkbox"/> Making a left turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing down <input type="checkbox"/> Accelerating Other _____
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4. Time/Speed/Damage Time of accident _____ Your vehicle's speed: _____ mph Other vehicle's speed: _____ mph Damage to your vehicle <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled	5. Details of Accident Visibility at time of accident <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Who hit who/what? <input type="checkbox"/> You hit other vehicle <input type="checkbox"/> Other vehicle hit you You hit... (object) _____	6. Road conditions Road conditions at time of accident <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean and dry Point of impact <input type="checkbox"/> Head-On <input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Rear-End <input type="checkbox"/> Left Rear <input type="checkbox"/> Right Rear
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7. Body Position, etc. Did you see the accident coming? Yes <input type="checkbox"/> <input type="checkbox"/> No Were you braced for the impact? Yes <input type="checkbox"/> <input type="checkbox"/> No Did you have a seat belt on? Yes <input type="checkbox"/> <input type="checkbox"/> No Did you have a shoulder harness on? Yes <input type="checkbox"/> <input type="checkbox"/> No	Does your vehicle have headrests? Yes <input type="checkbox"/> <input type="checkbox"/> No What was the position of your headrest at the time of the impact? <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of neck What was the direction of your head at the time of the impact? <input type="checkbox"/> Facing straight forward <input type="checkbox"/> Turned to the right <input type="checkbox"/> Turned to the left
Did driver side air bags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No Did passenger side airbags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No Did side airbags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No	

8. Did you lose time from work?

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 <input type="checkbox"/> <input type="checkbox"/> No If yes, describe: _____ Did you lose consciousness during the injury? Yes <input type="checkbox"/> <input type="checkbox"/> No If yes, for how long? _____ Your vehicle's estimated damage? Damage to their vehicle: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled Did police show up at the scene? Yes <input type="checkbox"/> <input type="checkbox"/> No Was an accident report filled out? Yes <input type="checkbox"/> <input type="checkbox"/> No	10. After the accident: Check off your symptoms right after and a few days following: <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Mid back pain <input type="checkbox"/> Cold hands <input type="checkbox"/> Neck pain <input type="checkbox"/> Nausea <input type="checkbox"/> Low back pain <input type="checkbox"/> Cold feet <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Confusion <input type="checkbox"/> Nervousness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of taste <input type="checkbox"/> Depression <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Tension <input type="checkbox"/> Toe numbness <input type="checkbox"/> Anxious <input type="checkbox"/> Loss of smell <input type="checkbox"/> Irritability <input type="checkbox"/> Constipation <input type="checkbox"/> Chest Pain <input type="checkbox"/> Pain behind eyes <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleeping problems Others: _____
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11. Emergency Room? Where did you go after the accident? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Hospital ER <input type="checkbox"/> Private Doctor How did you get there? <input type="checkbox"/> Drove self <input type="checkbox"/> Somebody else <input type="checkbox"/> Ambulance <input type="checkbox"/> Police Were X-rays done? Yes <input type="checkbox"/> <input type="checkbox"/> No Was lab work done? Yes <input type="checkbox"/> <input type="checkbox"/> No Body parts X-rayed? _____ What lab work? _____ The X-rays revealed: _____ Treatments: <input type="checkbox"/> Cervical Collar <input type="checkbox"/> 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 <input type="checkbox"/> <input type="checkbox"/> No Types of treatments received: _____ How many treatments received? ____ Currently treating? Yes <input type="checkbox"/> <input type="checkbox"/> No Did treatments benefit you? Yes <input type="checkbox"/> <input type="checkbox"/> No Last visit date: ____/____/____ 2. Dr. _____ First visit date: ____/____/____ Types of treatments received: _____ How many treatments received? ____ Currently treating? Yes <input type="checkbox"/> <input type="checkbox"/> No Did treatments benefit you? Yes <input type="checkbox"/> <input type="checkbox"/> No Last visit date: ____/____/____
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