

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

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 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?
 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: ____/____/____