## Auto Accident Form

**Name:** ______________________________ **Today's Date:** _____ / _____ / _____

**Date of Accident:** _____ / _____ / _____

**History of Occurrence:**
- ❑ Pedestrian ❑ Passenger – left rear ❑ Passenger – center rear ❑ Passenger – middle front
- ❑ Driver ❑ Passenger – right rear ❑ Passenger – right front

**Patient Vehicle Type:**
- ❑ Compact ❑ Full-size ❑ Pick-up ❑ Other: _____________
- ❑ Mid-size ❑ SUV ❑ Motorcycle

**Second Vehicle Type:**
- ❑ Compact ❑ Full-size ❑ Pick-up ❑ Other: _____________
- ❑ Mid-size ❑ SUV ❑ Motorcycle

**Third Vehicle Type:**
- ❑ Compact ❑ Full-size ❑ Pick-up ❑ Other: _____________
- ❑ Mid-size ❑ SUV ❑ Motorcycle

**Road Conditions:**
- ❑ Dry ❑ Wet ❑ Foggy ❑ Other: _____________
- ❑ Icy ❑ Clear ❑ Dark

**Road Type:**
- ❑ Concrete ❑ Gravel ❑ Other: _____________
- ❑ Asphalt ❑ Dirt

Were you aware the accident was going to occur? ❑ Yes ❑ No

Were you wearing a seat belt? ❑ Yes ❑ No

Does your car have a headrest? ❑ Yes ❑ No

Did your airbag deploy? ❑ Yes ❑ No

What position was the headrest in? ❑ Up ❑ Middle ❑ Down

**Head position:**
- ❑ Looking straight ahead ❑ Right up ❑ Right down
- ❑ Right level ❑ Left up ❑ Left down
- ❑ Left level ❑ Looking up ❑ Looking down

Was your vehicle braking? ❑ Yes ❑ No

Was your 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

*Revised 11/2013*

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 another vehicle | on the: | ❑ Front | ❑ Right | ❑ Top |
| ❑ Hit another vehicle | | ❑ Front-right | ❑ Right-rear | |
| ❑ Hit by an object | | ❑ Front-left | ❑ Left-rear | |
| ❑ Hit an object | | ❑ Left | ❑ Rear | |

**Second Impact:**

| | | | | |
|---|---|---|---|---|
| ❑ Hit by another vehicle | on the: | ❑ Front | ❑ Right | ❑ Top |
| ❑ Hit another vehicle | | ❑ Front-right | ❑ Right-rear | |
| ❑ Hit by an object | | ❑ Front-left | ❑ Left-rear | |
| ❑ Hit an object | | ❑ Left | ❑ Rear | |

**Collision Results**

**Body was thrown:** ❑ Backward ❑ Forward ❑ Left ❑ Right ❑ Cannot remember

| | | | |
|---|---|---|---|
| **Head Hit:** | ❑ Airbag | ❑ Another person's body | ❑ Side window/door |
| | ❑ Front windshield | ❑ Rear-view mirror | ❑ Dashboard |
| | ❑ Windshield | ❑ Back of front seat | ❑ Cannot remember |
| **Chest Hit:** | ❑ Another person's body | ❑ Back of front seat | ❑ Side window/door |
| | ❑ Steering Wheel | ❑ Dashboard | |
| **Shoulders Hit:** | ❑ Another person's body | ❑ Back of front seat | ❑ Shoulder harness |
| | ❑ Side window/door | | |
| **Knees Hit:** | ❑ Another person's body | ❑ Back of front seat | ❑ Center console |
| | ❑ Door panel | ❑ Steering wheel | ❑ Dashboard |
| **Hips Hit:** | ❑ Another person's body | ❑ Back of front seat | ❑ Center console |
| | ❑ Door panel | ❑ Steering wheel | ❑ Dashboard |

## Vehicle Damage

| | | | | |
|---|---|---|---|---|
| **First 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 |

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

When were you hospitalized?
❑ Immediately
❑ Later the same day
❑ The 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 neurologist
❑ See orthopedist ❑ Over the counter medication
❑ Prescription Medication
❑ Other: ____________________________________________

Did you have any x-rays taken? ❑ Yes ❑ No
If yes, what areas? ____________________________________________________

What are your current symptoms? ❑ Pain ❑ Numbness ❑ Stiffness ❑ Weakness

**Signature:** ________________________________________ **Date:** _____ / _____ / _____