

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_