Patient:_____ Date of Accident:_____Claim #:_____

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
❑ Read-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

Did driver side air bags deploy? **Yes❑ ❑ No** Did passenger side airbags deploy? **Yes❑ ❑ No** Did side airbags deploy? **Yes❑ ❑ No**

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 stiffnes ❑ 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: ____/____/____

Patient Signature:_____Date Signed:_____