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AUTO ACCIDENT FORM

1. What was the date of the accident?_____
2. What time did the accident occur?_____
3. How many vehicles were involved in the accident?_____
4. What was the estimated damage to the vehicle you were in? _____
5. What was road and direction did accident occur in? _____
6. What city and state did the accident occur in? _____
7. What type of impact was the auto accident? _____
8. Did your vehicle hit anything after the accident? if yes, please describe

_____

9. Where were you sitting in the vehicle during the accident? _____
10. Did you know the accident was coming?_____
11. What type of vehicle were you in? _____
12. What type of vehicle impacted yours? _____
13. At the time of the impact, how fast was your vehicle moving? _____
14. At the time of impact, how fast was the other vehicle moving? _____
15. During and after the crash what happened to your vehicle? (circle all that apply)
    - kept going straight
    - kept going straight hitting a car in front
    - was hit by another vehicle
    - spun around
    - spun around and hit a stationary object
    - hit a stationary object
16. Did you lose consciousness during the accident? -yes - no
17. How was your head positioned during the accident? _____
18. How was your torso positioned during the accident? _____
19. How were your hands positioned during the accident? _____
20. Did your head hit anything during the accident? -no - yes, please describe_____
21. Did your face hit anything during the accident? -no - yes, please describe_____
22. Did your shoulders hit anything during the accident? -no - yes, please describe_____
23. Did your neck hit anything during the accident? -no - yes, please describe_____

24. Did your chest hit anything during the accident? -no - yes, please describe_____

25.. Did your hips hit anything during the accident? -no - yes, please describe_____

26. Did your knees hit anything during the accident? -no - yes, please describe_____

27. Did your feet hit anything during the accident? -no - yes, please describe_____

28. What kind of headrest was in your vehicle?
    - movable fixed headrest
    - nonmovable fixed headrest
    - no headrest

29. Where was the headrest positioned on your head? _____

30. Did you have your seatbelt on during the accident? - yes -no

31. Did you slide out of your seatbelt during the accident? _____

32. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totalled
- side window	- front right door	
- rear window	- back left door	

33. Choose the items that dented inward
    - floorboards - side door - dashboard

34. Choose the doors that would not open as a result of the accident
    - front left - front right
    - rear left - rear right

35. Did you go to the hospital? If no, why and do not answer 38-43
_____

36. How did get to the hospital? _____

37. What was the name of the hospital? _____

38. Were you hospitalized overnight? _____

39. Circle what you were prescribed at the hospital
    - pain medication - muscle relaxors - neck brace

40. Did you receive any stitches for any cuts at the hospital? _____

41. Were x rays taken at the hospital? If yes, which area was taken?
_____

I certify that the statements made on this form are complete and accurate to the best of my knowledge. I agree to notify the doctor immediately if I have any changes in my health condition.

Patient Name (Printed)_____

Patient Signature_____ **Date:**_____