Automobile Accident Description

Personal Information:

Last Name:	First Name:	Mid. Init.:
Address:	City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:
Date of Birth:	Date of Injury/Onset:	

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

Your vehicle type

❑ Car ❑ Station Wagon
❑ Van ❑ Pickup Truck
❑ Large Truck ❑ Bus
❑ Other _____

Your position in vehicle

❑ Driver ❑ Front Passenger
❑ Left Rear Passenger
❑ Right Rear Passenger
❑ Other _____

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 _____

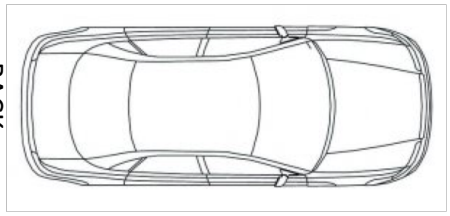
Road conditions

❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry

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
Hospital Name and City_____

LEFT



RIGHT

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram.

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 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 impact?
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side airbags deploy? Yes ❑ ❑ No Did passenger side airbags deploy? Yes ❑ ❑ No Did side airbags deploy? Yes ❑ ❑ No

During the accident

Did your body strike the inside of the vehicle? Yes ❑ ❑ No
If yes, describe: _____
Did you lose consciousness during the injury? Yes ❑ ❑ No
If yes, for how long?_____

Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled
Did police show up at the scene? Yes ❑ ❑ No
Was an accident report filled out? Yes ❑ ❑ No

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: _____

Please explain the details of the accident to the best of your knowledge:

Patient Sign & Date:_____ **Date:**_____