

Auto Accident Form



BETTER LIFE
WELLNESS CENTER

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Date of Accident: _____

Please mark your involvement in the accident:

Pedestrian Driver Passenger

What are your current symptoms?

Pain Numbness Stiffness Weakness

Patient was located: Driver

Passenger: middle front right front left rear middle rear right rear

Patient vehicle type: Compact Mid-size Full-size SUV Pick-up Motorcycle

Second vehicle type: Compact Mid-size Full-size SUV Pick-up Motorcycle

Third vehicle type: Compact Mid-size Full-size SUV Pick-up Motorcycle

Road Conditions: Clear Dark Dry Foggy Icy Wet

Road Type: Asphalt Concrete Dirt Gravel

Were you aware accident was going to occur? Yes No **Did the airbag deploy?** Yes No

Were you wearing a seatbelt? No Yes; Lap belt only Lap belt + shoulder harness

Does your car have a head rest? Yes No

What position was the head rest in? Up Middle Down

Patient's Looking straight ahead Looking up Looking down

Head Position Right level Right up Right down Left level Left up Left down

ACCIDENT DETAILS

Was your car breaking? Yes No

Was your car 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 second car breaking? Yes No

Was the second car 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 car breaking? Yes No

Was the second car 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

Auto Accident Form, Continued

COLLISION DETAILS

First impact: hit by other vehicle hit other vehicle hit by object hit object

Location: front front-right front-left left right right-rear left-rear rear top

Second impact: hit by other vehicle hit other vehicle hit by object hit object

Location: front front-right front-left left right right-rear left-rear rear top

COLLISION RESULTS

Body was thrown: forward backward left right can't remember

back of the front seat side window/door another person's body headrest

Chest hit: airbag steering wheel dashboard back of the front seat

side window/door another person's body

Shoulders hit: shoulder harness side window/door back of the front seat another person's body

Knees hit: steering wheel dashboard back of the front seat door panel center console

another person's body

Hips hit: steering wheel dashboard back of the front seat door panel center console

another person's body

VEHICLE DAMAGE

Patient 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 continue.*

When were you hospitalized? immediately later same day next day date: _____

Transportation to hospital ambulance life flight private transportation

Hospital recommendations no instructions see this clinic see DC see own doctor

see orthopedist see neurologist prescription medication

other: _____

Did you have any xrays taken? No Yes; _____

list all areas