AUTOMOBILE ACCIDENT FORM

Patient Name: _____ Date: _____

Please complete the form carefully, checking or writing your answers as needed:

Date of Accident? _____ Time of Accident: _____ **AM** ☐ **PM** ☐

Where did the accident occur: City: _____ Street: _____

Road conditions were: Wet ☐ Dry ☐ Icy ☐ Other: _____

Did the police come to the scene? Yes ☐ No ☐

Please describe to the best of your ability what happened during this accident: _____

_____

_____

_____

_____

_____

The following questions pertain to you (the patient) and the vehicle you were traveling in:

Year: _____ Make: _____ Model: _____ of the car you were in.

Were you driving? Yes ☐ No ☐ If no, where were you in the car: _____

Were you aware of the approaching collision? Yes ☐ No ☐

Did you lose consciousness upon impact? Yes ☐ No ☐ If yes, for how long? _____

Were you wearing your seatbelt? Yes ☐ No ☐ If yes, was there a shoulder strap? _____

Was your car stopped at the time of impact? Yes ☐ No ☐

If yes, was the driver's foot on the break? Yes ☐ No ☐

If the car was moving, how fast were you going? _____ mph.

Were you moving at a: Steady speed ☐ Gaining speed ☐ Slowing down ☐

What was your body position at the time of impact:

☐ Head turned right ☐ Head straight ☐ Looking back (☐ Left ☐ Right)

☐ Head turned left ☐ Body in straight position ☐ Other: _____

On what part of the car did the following body parts hit (if any):

Head: _____ Left/Right hip: _____

Chest: _____ Left/Right leg: _____

Left/Right shoulder: _____ Left/Right knee: _____

Left/Right arm: _____ Other: _____

Did you get bleeding cuts from this accident? Yes ☐ No ☐

Did you get any bruises from this accident? Yes ☐ No ☐

Were you taken to the hospital? Yes ☐ No ☐ If yes, how did you get there? _____

Were X-Rays takend? Yes ☐ No ☐ If yes, what areas were X-Rayed? _____

Check symptoms you have noticed ***since*** the accident:

☐ Headaches	☐ Mid back pain	☐ Irritability
☐ Dizziness	☐ Numbness in fingers	☐ Buzzing in ears
☐ Fever	☐ Face flushed	☐ Loss of smell
☐ Neck pain	☐ Low back pain	☐ Chest pain
☐ Head feels heavy	☐ Numbness in toes	☐ Loss of balance
☐ Fatigue	☐ Depression	☐ Loss of taste
☐ Neck stiffness	☐ Nervousness	☐ Cold sweats
☐ Pins & needles in arms	☐ Shortness of breath	☐ Constipation
☐ Loss of memory	☐ Diarrhea	☐ Hands cold
☐ Sleeping problems	☐ Tension	☐ Stomach upset
☐ Pins & needles in legs	☐ Light bothers eyes	☐ Jaw pain
☐ Ears ring	☐ Fainting	☐ Feet cold

Please list any of the above symptoms that you had before this accident (if any), _____

_____

Have you been under a doctor's care as a result of this accident? Yes ☐ No ☐

If yes, please list the doctor's name: _____ Phone #: _____

Have you lost any days from work? Yes ☐ No ☐

If yes, dates absent from work: From _____ to _____

List any dates of limited work activities: _____ Date returned to normal work: _____

The following questions pertain to the other vehicle involved in the accident:

Year: _____ Make: _____ Model: _____ of the other car.

Was the other car moving at the time of impact? Yes ☐ No ☐

If yes, the estimated speed: _____ mph.

Were they moving at a: Steady speed ☐ Gaining speed ☐ Slowing down ☐

The following questions pertain to both parties auto insurance information:

Please provide the following information on **your** auto insurance (if you were in your own car). If you were driving or a passenger in another's vehicle give **their** auto insurance information:

Company name: _____ Insured's name: _____

Adjuster's name: _____ Phone #: _____ Policy #: _____

Please provide the information on the auto insurance of the **other party's vehicle** :

Company name: _____ Insured's name: _____

Adjuster's name: _____ Phone #: _____ Policy #: _____

Patient Signature: _____ **Date:** _____