

### 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:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Mid back pain       | <input type="checkbox"/> Irritability    |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Buzzing in ears |
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Face flushed        | <input type="checkbox"/> Loss of smell   |
| <input type="checkbox"/> Neck pain              | <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Chest pain      |
| <input type="checkbox"/> Head feels heavy       | <input type="checkbox"/> Numbness in toes    | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Depression          | <input type="checkbox"/> Loss of taste   |
| <input type="checkbox"/> Neck stiffness         | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Cold sweats     |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Loss of memory         | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Hands cold      |
| <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Tension             | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Light bothers eyes  | <input type="checkbox"/> Jaw pain        |
| <input type="checkbox"/> Ears ring              | <input type="checkbox"/> Fainting            | <input type="checkbox"/> 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:** \_\_\_\_\_