AUTO ACCIDENT REPORT FORM

Patient Name:_____ Date of Accident: _____

Time of Incident:_____ ☐ a.m ☐ p.m City of Accident:_____

Road conditions at the time of the incident: ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

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

Was an accident report filed? ☐ Yes ☐ No Were you taken to a hospital? ☐ Yes ☐ No

Hospital Name & City: _____

How did you get to the hospital? _____

Were X-Rays taken? ☐ Yes ☐ No

If yes, what was X-Rayed? ☐ Head ☐ Neck ☐ Upper Back ☐ Mid-Back ☐ Lower Back

☐ Other: _____

The following questions pertain to you, the patient, and the vehicle you were in:
Please explain the details of the accident to the best of your knowledge:

Were you seated in the vehicle? ☐ Yes ☐ No

Were you aware of the approaching collision, or did the impact catch you by surprise? ☐ Aware ☐ Surprise

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

How far is the top of the headrest/seatback from the top of your head?

Approximately: ____ inches ☐ Above ☐ Below

Were you wearing a seatbelt? ☐ Yes ☐ No If yes, what type? ☐ Lap Belt ☐ Shoulder Belt

Vehicle Information & Velocity:

Vehicle Year: _____ Make: _____ Model: _____

Was your car moving, or stopped? ☐ Moving ☐ Stopped

If your car was moving:

How fast were you going? Approximately _____ m.p.h

Just before impact, the car was: ☐ Slowing Down ☐ Speeding Up ☐ Constant Speed

Were there bleeding cuts caused by the accident? ☐ Yes ☐ No

Where: _____

Did the accident cause any bruises? ☐ Yes ☐ No

Where: _____

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Where did the following body parts hit during the accident:

Head:_____
Chest:_____
R/L Shouder:_____
R/L Arm:_____
R/L Hip:_____
R/L Leg:_____
R/L Knee:_____
Other:_____

Which (if any) of the following car parts broke during the accident:
☐ Windshield ☐ Steering Wheel ☐ Front Seat ☐ Back Seat ☐ Side Window (R/L)
☐ Other: _____

Was the trunk of your body pointed straight forward at the time of impact? ☐ Yes ☐ No
If No, which direction was it pointed, and by how much?
_____
Was your head pointed straight forward at the time of impact? ☐ Yes ☐ No
If No, which direction was it turned, and by how much?
_____

If you have been involved in previous auto accidents, please list the year of each accident:
_____
_____
Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No
Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

❑ Headache ❑ Irritability ❑ Numbness in Toes ❑ Face Flushed ❑ Feet Cold
❑ Neck Pain ❑ Chest Pain ❑ Shortness of Breath ❑ Buzzing in Ears ❑ Hands Cold
❑ Neck Stiff ❑ Dizziness ❑ Fatigue ❑ Loss of Balance ❑ Stomach Upset
❑ Sleeping Problems ❑ Head seems Too Heavy ❑ Depression ❑ Fainting
❑ Constipation ❑ Back Pain ❑ Pins & Needles in Arms ❑ Lights Bother Eyes
❑ Loss of Smell ❑ Cold Sweats ❑ Nervousness ❑ Pins & Needles in Legs
❑ Loss of Memory ❑ Loss of Taste ❑ Fever ❑ Tension ❑ Numbness in Fingers
❑ Ears Ring ❑ Diarrhea ❑ Symptoms Other Than Above:_____
_____

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No
If yes, please describe in detail:_____

Signature:_____Date:_____

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