AUTO ACCIDENT INFORMATION

Name:	Today's Date:	Date of Accident:
How many were in your vehicle at time of accident?	How many vehicles were involved?	
Location of accident: (streets)		
Nearest intersection:		
City / town accident took place:		State:
Which direction were you headed? ☐ North ☐ South ☐ East ☐ West ☐ Other		
Did the accident involve a hit and run driver? ☐ Yes ☐ No		
Year, Make and Model of the vehicle you were in:		
Were you in your own vehicle or someone else's at the time of the accident? ☐ my own vehicle ☐ my spouse's ☐ my parent's ☐ a friend's ☐ other _____		
If you were in someone else's vehicle, answer the following: Name of Owner: Address of Owner:		
Were there any witnesses? ☐ Yes ☐ No		
Was a ticket or citation issued by a police officer as a result of the accident? ☐ YES ☐ NO Did you pick up a police report of the accident? ☐ YES ☐ NO		
Name of the hospital were you taken to? ☐ Christus Good Shepherd ☐ Longview Regional ☐ Other _____		
Make and model of the other vehicle?		
Which direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West ☐ Other		
Approximate speed the other vehicle was traveling:		
Do you have any other information concerning the other parties involved? ☐ YES ☐ NO (if yes, please provide our office with this information or a copy of this information)		

Automobile Accident Description

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

1. Your vehicle type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other_____

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other_____

3. 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_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
☐ Mild ☐ Moderate
☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact
☐ Head-On ☐ Left Front ☐ Right Front
☐ Read-End ☐ Left Rear ☐ Right Rear

7. 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 the 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 the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? Yes☐ ☐ No Did passenger side airbags deploy? Yes☐ ☐ No Did side airbags deploy? Yes☐ ☐ No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? Yes☐ ☐ No
If yes, describe:_____
Did you lose consciousness during the injury? Yes☐ ☐ No
If yes, for how long?_____
Your vehicle's estimated damage?_____
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled
Did police show up at the scene? Yes☐ ☐ No
Was an accident report filled out? Yes☐ ☐ No

10. 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 stiffnes ☐ 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:_____

11. 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
Were X-rays done? Yes☐☐No **Was lab work done?** Yes☐☐No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed:_____
Treatments: ☐ Cervical Collar ☐ Ice **Other:**_____
Medications:_____
Follow-up instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr._____ First visit date: ___/___/___
Specialty:_____ X-rays done? Yes☐ ☐ No
Types of treatments received:_____
How many treatments received?____ Currently treating? Yes☐ ☐ No
Did treatments benefit you? Yes☐ ☐ No
Last visit date: ___/___/___
2. Dr._____ First visit date: ___/___/___
Types of treatments received:_____
How many treatments received?____ Currently treating: Yes☐ ☐ No
Did treatments benefit you? Yes☐ ☐ No
Last visit date: ___/___/___