

Name: _____

Date of Accident: _____

Primary Phone Number: _____

Today's Date: _____

Describe the Vehicle:

Vehicle Type:

- Bus
- 4 Door Sedan
- SUV
- Station Wagon
- Pick Up Truck
- Truck
- Van
- 2 Door Sedan
- Other: _____

Vehicle Size:

- Full Size
- Mid Size
- Small Truck
- Compact
- Sub Compact

Position in Vehicle:

- Driver
- Left
- Middle
- Right
- Front Seat
- Back Seat
- Third Row

Wearing Seat Belt? Yes No

Describe the Accident:

Action of the Patient's Vehicle:

- Traveling straight
- Traveling straight through intersection
- Crossing an intersection
- Slowing in traffic
- Slowing to stop for a stop sign
- Slowing to stop for a red light
- Slowing in traffic for a pedestrian
- Stopped for a pedestrian
- Stopped in Traffic
- Stopped at red light
- Turning left
- Turning right
- Traveling in a rotary
- Stopped in an intersection
- Traveling slower than the speed limit
- Traveling faster than the speed limit

How was Patient's Vehicle Hit:

- Head-on
- Left Front
- Right Front
- Left Rear
- Right Rear
- Rear-ended
- Sideswiped on the left
- Sideswiped on the right

Amount of Damage to Vehicle:

- Minimal
- Moderate
- Extensive
- Complete
- Unknown

Describe Other Vehicle:

- Compact car
- Full-sized car
- Mid-sized car
- Subcompact car
- Semi-trailer
- Small Truck
- Pickup truck
- SUV
- Full-sized van
- Mini-van
- Box truck

Damage to Other Vehicle:

- Minimal
- Moderate
- Extensive
- Complete
- Unknown

Time of Day:

- Lunch time or mid-day
- Dawn or early morning
- Dusk or early evening
- Nighttime
- Dark with street lights
- Dark without street lights
- Mid-morning
- Mid-afternoon

Weather Conditions:

- Clear
- Foggy
- Cloudy
- Rainy
- Snowing
- Sleet
- Sunny

Road Conditions:

- Dry
- Wet
- Snowy
- Icy

Visibility:

- Poor
- Fair
- Good

Describe Moment of Impact

Body Position at Impact:

- Leaning forward
- Slouched down
- Straight
- Turned left
- Turned right

Direction Body Was Thrown:

- Backward then forward
- Forward then backward
- To the left
- To the right
- About the vehicle
- Outside the vehicle

Head Position at Impact:

- Straight
- Tilted Forward
- Turned left
- Turned right

Direction Head Was Thrown:

- Backward then forward
- Forward then backward
- Side to side

Type of Passive Restraint:

- Lap Belt
- Shoulder Belt
- Shoulder Lap Belt
- Child Seat/ Booster Seat

Did the Airbags Deploy?

- Yes
- No

Position of Head Rests:

- High Position
- Middle Position
- Low Position
- Not Installed
- Installed/ Unsure of position

Braced for Impact?

- Yes
- No

What Happened Immediately Following the Accident

The Initial Reaction:

- Shaken
- Upset
- Nervous
- Confused
- Frightened
- Other: _____

Where Did The Pain Occur?

- Head
- Neck
- Upper Back
- Mid Back
- Lower Back
- Other: _____

Lost Consciousness?

- Yes
- No
- Unsure

Type of Emergency Care At Scene:

- Bandaging
- Bracing
- Neck Collar
- Splinting
- Went to hospital in ambulance

Destination After Accident:

- Home
- School
- Work
- Hospital
- Urgent Care
- Other: _____

Who Drove Patient? _____

Where Were Cuts Located? _____

Post Accident Treatment:

Date of Hospital/Doctor Visit: _____

Name of Hospital/Clinic: _____

Examining Physician: _____

Date of Discharge: _____

Was Patient Admitted? Yes No

Were X-rays taken?

- Yes (If so, where? _____)
- No

Were CAT scans given?

- Yes (If so, where? _____)
- No

Was an MRI performed?

- Yes (If so, where? _____)
- No

Diagnosis of Injury:

Treatments Administered:

- None
- Adjustments
- Bandaging
- Casting
- Hot Packs
- Oral Medication
- Other: _____

Recommendations:

- Follow treatment plan
- Receive no further care
- Rest
- Take time off from work
- See Specialist: _____
- No Recommendations Given

Medication Prescribed:

- Anti-Inflammatory
- Muscle Relaxer
- Pain Reliever
- Antibiotic
- Over-The-Counter

- This patient denies prior treatment for this complaint.
- The patient reports that no radio-graphs were taken for this injury.