Patient's Name:____ Today's Date:_____________

AUTO ACCDIENT MECHANISM OF INJURY FORM

Date of Collision: __________________________ Hour of Accident:______________ AM/PM

Please describe how the collision happened: ____
____
____
____

What was your position in the car (Circle) **Driver/ Front Passenger / Left Rear / Right Rear**

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

Did the airbags deploy? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

Angle of impact: **Front / Back / Left / Right / Other :**____

If second collision- Angle of 2nd impact: **Front / Back / Left / Right / Other:**_________________________

1.) In relation to the back of your head, was your headrest set: **Low / Middle / High**

2.) Were you surprised by the impact? **Yes / No**

If "NO", how did you brace? With hands / With Feet

3a.) Where was your head facing at the time of impact? **Straight ahead/ Left / Right**

3b.) Were you leaning forward at time of impact? **Yes / No**

4a.) What type and year of vehicle were you in? ____

____

4b.) What was the approximate speed of your vehicle when the accident occurred? _______mph

5.) What type and year of vehicle struck yours? ____
____

6.) Were you wearing a seatbelt? Yes / No What type: **Lap Belt / Shoulder Belt / Both**

7.) Did you feel pain immediately after the accident? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Patient's Name:____ Today's Date:____________

Did you strike anything at the time of impact? **Yes / No** If "YES", specify what part of your body struck what (i.e. head, chest, chin, shoulder, knee, etc.)

Steering Wheel:	Windshield:
Dashboard:	Roof:
Left Side Door:	Right Side Door:
Left Window:	Right Window:
Other:	

Did your seat break or bend? **Yes / No**

Police and Ambulance

Was the accident reported to the police? **Yes / No**

Were there traffic citations issued? **Yes / No** If "YES" to whom? ________________________

Did you go to the hospital? **Yes / No** If "YES", when? ________________________________

If "YES" how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? ____________________________________

Name of Hospital: _________________________ Attended by Dr. _________________________

What treatment was given? (circle all that apply)**: None / X-rays / Pain Medicine / Stitches / Muscle Relaxants / Bandaged / Cervical collar / Physical Therapy / Instructed Regarding Concussion/ Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician/ Referred to this office/ Other**

What other doctor have you seen as a result of this injury? _________________________________

Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**

Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**

Symptoms other than above: ____

____ ____________________

Patient Signature Date