

MOTOR VEHICLE ACCIDENT FORM (Page 1)

Patient Name: _____ Date: _____

Date of injury: _____ Time of injury: _____ AM PM

City where crash occurred: _____ Was the street wet or dry? Wet Dry

Street (location) where accident occurred: _____

What is the estimated damage to your vehicle? \$ _____

Who made damage estimates on your vehicle? _____

Who owns the vehicle you were involved in? _____

Yes No Did the police come to the accident scene?

Yes No Did the police make a written report?

Yes No Were photographs taken of your vehicle? If yes, who took them: _____

DESCRIBE HOW THE CRASH HAPPENED:

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile accident you were involved in:

Single-car crash Two-vehicle crash Three or more vehicles

Rear-end crash Side crash Rollover

Head-on crash Hit guard rail, tree, or object Ran off the road

Other (Describe): _____

DESCRIBE THE VEHICLE YOU WERE IN:

Make: _____ Model: _____ Year: _____

Small-sized car Mid-sized car Large-sized car

Pick-up truck Van Sport Utility Vehicle

2 Door vehicle 4 Door vehicle Large truck, bus, semi truck

Sedan Hatchback Stationwagon

DESCRIBE THE OTHER VEHICLE

Make: _____ Model: _____ Year: _____ Unknown

Small car Mid-sized car Van

Pick-up truck/sports utility Full-sizes car Large truck, bus, semi-truck

MOTOR VEHICLE ACIDENT FORM (Page 2)

Estimated Crash Speeds:

Your Vehicle: _____ Other Vehicle: _____

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

- Slowing down
 Stopped with brake engaged
 Stopped with out brake
 Gaining speed
 Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

- Slowing down
 Stopped
 Gaining speed
 Moving at steady speed
 Unknown speed
 Other

DURING AND AFTER THE CRASH, YOUR VEHICLE:

- Kept going straight, not hitting anything
 Kept going straight, hitting car in front
 Was hit by another vehicle
 Spun around, not hitting anything
 Spun around, hitting another car
 Spun around, hitting object other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines from the body regions on the left side and match to the right side.

BODY REGION

Head
Face
Shoulder
Arm/hand
Front chest wall
Side chest wall
Hip/abdomen
Knee
Leg
Foot

OBJECT YOU HAD CONTACT WITH

Windshield
Side window
Side door
Dashboard
Knee bolster/glove compartment
Seatbelt
Frame of car near windows
Roof of window
Another occupant/animal
Roof
Steering wheel/column

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

- Windshield
 Steering wheel
 Dash
 Seat frame
 Side or rear window
 Mirror
 Knee bolster
 Brake Pedal
 Other

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES NO

- Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
 Did the side door touch your body during the crash?
 Was the door(s) of your vehicle damaged to a point where you could not open the door?
 Did your body slide under the seatbelt?
 Did an airbag deploy in your vehicle during the crash?
 Were you intoxicated (alcohol) at the time of the crash?

MOTOR VEHICLE ACCIDENT FORM (Page 3)

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES NO

- Were you wearing a seatbelt?
If yes, does your seatbelt have a: Lap and shoulder strap, Lap belt only
- Indicate if you had any portion of your seatbelt positioned behind your back or shoulder.
- Were you holding onto the steering wheel (driver only) at the time of impact?
If yes, indicate where each hand was positioned (Use time clock face as your reference point)

Left hand: Not on wheel, Yes, hand at ____ o'clock, Hand elsewhere

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

- Movable/adjustable head restraint Fixed, non-movable head restraint
 No headrests in my vehicle Bench seat in your vehicle without head restraint

Please indicate how your head restraint was positioned at the time of crash (if present):

- At the top of the back of your head Midway height of the back of your head
 Lower height of the back of your head Located at the level of your neck
 Level of your shoulder blades

Estimated distance between back of head and front of headrest: _____

BRUISING AFTER THE CRASH

YES NO

- Did your body have any bruising (areas that were visibly black and blue) after the crash? If yes indicate where: _____

AWARENESS AND BODY POSITION DESCRIPTIONS : Check all areas that apply to you.

- You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
 You were aware of the impending crash and relaxed before the collision.
 You were aware of the impending crash and braced yourself.
 Your body, torso, and head were facing straight ahead.
 You had your head and/or torso turned at the time of collision: Turned to the left, Turned to the right
Describe how far you were turned/twisted and why?
 You were leaning forward at the time of impact resulting in a gap between your body and the seatback.
 Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting.

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom does not apply to you.

SYMPTOM LIST	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS CURRENTLY	HAD SIMILAR SYMPTOMS WITHIN ONE YEAR BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw Pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Rib cage pain				
Low back pain/soreness/aching				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down back of leg				
Pain primarily in front of thighs				
Knee pain				
Ankle/foot pain				
Other				

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor you went to after your injury or condition began and list all providers (all types of doctors or therapists) up to your last provider seen and check all that apply for each. Be certain to list these in sequence from first to last.

(1) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____ Date _____

Indicate what was done:

- | | | |
|---|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> IME exam or consult only | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injections (s) |
| <input type="checkbox"/> X-ray of chest/mid back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
| <input type="checkbox"/> X-ray of low back | <input type="checkbox"/> Muscle Stimulation | <input type="checkbox"/> Neck collar (brace) |
| <input type="checkbox"/> Other X-rays | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Low back brace |
| <input type="checkbox"/> MRI/CT scan | <input type="checkbox"/> Anti-inflammatory medications | <input type="checkbox"/> Heat packs |
| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other |

Indicate if treatment with this provider: Helped Did not help Other

(2) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____ Date _____

Indicate what was done:

- | | | |
|---|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> IME exam or consult only | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injections (s) |
| <input type="checkbox"/> X-ray of chest/mid back | <input type="checkbox"/> Muscle massage/myotherapy | <input type="checkbox"/> Wrist brace-splint |
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| <input type="checkbox"/> EMG/Nerve conduction study | <input type="checkbox"/> Pain medications | <input type="checkbox"/> Ice packs |
| <input type="checkbox"/> Other tests | <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other |

Indicate if treatment with this provider: Helped Did not help Other

(3) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____ Date _____

Indicate what was done:

- | | | |
|---|--|--|
| <input type="checkbox"/> Exam-consultation | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Exercises |
| <input type="checkbox"/> IME exam or consult only | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> X-ray of neck | <input type="checkbox"/> Spinal adjustments | <input type="checkbox"/> Injections (s) |
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Indicate if treatment with this provider: Helped Did not help Other