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 ☐ Station wagon

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 ACCIDENT 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 without 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	OBJECT YOU HAD CONTACT WITH
Head	Windshield
Face	Side Window
Shoulder	Side Door
Arm/Hand	Dashboard
Front chest wall	Knee bolster/Glove compartment
Side chest wall	Seatbelt
Hip/Abdomen	Frame of car near windows
Knee	Roof of window
Leg	Another occupant/Animal
Foot	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?

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 <u>head restraint</u> 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 the neck
☐ Level of your shoulder blade

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.

EMERGENCY ROOM AND DISABILITY DATES? (PAGE 4)

Patient Name:_____ Dates:_____

YES	NO	
☐	☐	Did you go to the emergency room afterward? If yes, date and time:_____ Name of the emergency room? City:
☐	☐	Did you go to the emergency room in the ambulance? If yes, name of ambulance:
☐	☐	Did you or another person drive you to the emergency room? Name of person:
☐	☐	Were you hospitalized after being seen in Emergency Room? If yes, how many days:
☐	☐	Did the emergency room doctor take X-rays? Check what regions x-rays were taken: ☐ Skull/Face x-rays ☐ Ribs/Chest ☐ Neck or Middle back x-rays ☐ Collar bone ☐ Low back or Hip/Pelvis x-rays ☐ Shoulder, Arm or Hand ☐ Leg or Foot ☐ Other
☐	☐	Did the hospital or clinic take MRI or CT of your body? If yes, indicate where taken: ☐ Skull ☐ Neck ☐ Low back or hip/pelvis ☐ other
☐	☐	Did you have any broken bones/fractures? If yes, where:
☐	☐	Did you have a cast put on for any sprain or fracture? If yes, type/location:
☐	☐	Did you have any dislocations? If yes, where:
☐	☐	Did you have any cuts or lacerations? If yes, where:
☐	☐	Did you have any skin abrasions? If yes, where:
☐	☐	Did you require any stitching for cuts? If yes, where:
☐	☐	Did you have any visible bruises or lumps? If yes, where:
☐	☐	Did you have any visible bruises along the shoulder or lap portions of your seatbelt
☐	☐	Did the Emergency Room doctor give you any pain medications?
☐	☐	Did the Emergency Room doctor give you any muscle relaxants?
☐	☐	Did the Emergency Room doctor give you any other medications/prescriptions?
☐	☐	Were you told you had a herniated or bulging disc in your neck or back? If yes, where:
☐	☐	Were you given a neck collar or back brace to wear?
☐	☐	Did you require any surgery after the accident? If yes, describe type and date:
☐	☐	Were you hospitalized overnight? If yes, indicate dates hospitalized:

HOW SOON DID YOU FIRST NOTICE ANY PAIN OR SORENESS AFTER YOU YOUR INJURY?

☐ Less than 24 hours after injury	☐ Began 1-7 days after injury	☐ Began ___ days after injury

IF YOU <u>DID NOT</u> SEE A DOCTOR FOR THE FIRST TIME UNTIL AFTER TWO WEEKS FROM THE INJURY DATE, INDICATE WHY: (Check all that apply only if you had delay in seeing a doctor)

☐ No pain was noticed	☐ No appointment schedule available	☐ Thought pain would go away
☐ No transportation	☐ Work/home schedule conflicts	☐ Other:

DISABILITY-HAVE YOU BEEN ABLE TO WORK SINCE INJURY?

☐ YES ☐ NO Have you lost days off work? If yes, you were off work: ☐ Partially ☐ Completely
Please list all dates off work: From:_____ to_____.

•If you had neck and/or back pain so severe that you were unable to get out of bed, how many hours after the accident did you develop this disabling level of pain?_____Hours.

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE (PAGE 5)

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 (PAGE 6)

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:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ IME exam or consult only	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck	☐ Spinal adjustments	☐ Injection (s)
☐ X-ray of chest/mid back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back	☐ Muscle stimulation	☐ Neck collar (brace)
☐ Other X-rays	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/ Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests	☐ Muscle relaxants	☐ 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:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ IME exam or consult only	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck	☐ Spinal adjustments	☐ Injection (s)
☐ X-ray of chest/mid back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back	☐ Muscle stimulation	☐ Neck collar (brace)
☐ Other X-rays	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/ Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests	☐ Muscle relaxants	☐ 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:

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

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