IF YOU WERE INVOLVED IN AN AUTO TRAUMA, PLEASE FILL OUT THE FOLLOWING:

Patient Name _____ PT#_____
Date of Collision_____/_____/_____ Location_____
Your auto Insurance Company _____Claim #_____Phone#_____
The other persons Insurance Company_____ Claim # _____ Phone #_____

Body Position:
□ Driver
□ Front Passenger
□ Right Rear Passenger
□ Left Rear Passenger
□ Pedestrian
□ Other:_

Your vehicle type:
□ Car
□ PU Truck
□ Bus
□ Van
□ SUV
□ Motorcycle
□ Other_____

What were you doing?
□ Proceeding along
□ Stopped at an intersection
□ Making a left turn
□ Making a right turn
□ Slowing down
□ At a stoplight
□ Parking
□ Stopped in traffic
□ Standing
□ Walking
□ Running
□ Other _____

Who hit whom?
□ Your vehicle hit them
□ You were hit by another vehicle
□ Double collision
□ Hit by an oncoming vehicle

How were you hit?
□ Rear end
□ Front end
□ Left front
□ Right front
□ Left rear
□ Right rear
□ Other

Road conditions:
□ Icy
□ Snowy
□ Wet
□ Sandy
□ Clear and Dry

Visibility:
□ Poor
□ Fair
□ Good

Time and Speed:
Time of trauma _____ am pm
Date of trauma_____

Your vehicle speed ____mph

Their vehicle speed ____ mph

Bracing:
Did you see the car coming?
Y N N/A
Were you braced for the impact?
Y N N/A

Head position: □ Looking forward □ Looking left □ Looking right

Were you wearing seat belts?
Y N N/A
Were you wearing a shoulder strap?
Y N N/A

Body Position:
Head position:
□ Looking forward
□ Looking left
□ Looking right

Head rest position
□ Even with the head
□ Above the head
□ At the neck level

Did the airbag deploy?
Y N N/A
Did you plant your feet firmly on the floorboard or brake?
Y N N/A

What did your body hit inside the vehicle?
□ The front seat
□ Steering wheel
□ Side window
□ Windshield
□ Headrest
□ Nothing

Did you…
□ Lose consciousness?
□ See the police?
□ File and accident report?
The Vehicle damage was…
□ Mild □ Moderate □ Severe
□ <$1500 □ $1,500 to $3,500
□ >$3,500 □ Totaled

After the accident you went …
□ Home
□ To Hospital
□ To work
□ Other
_____

Immediately following the accident you felt…
□ No pain □ Mild pain
□ Moderate pain
□ Severe pain
As time passed the problems…
□ Worsened
□ Stayed the same

Did you notice:
□ Bruises
□ Lacerations
What treatment did you receive?
□ Self medicate
□ Prescriptions
□ Used ice or heat
□ None

Work and school:
□ Off work
□ Off work with a note
□ Works in spite of pain
□ Work no problem
□ Unemployed
□ Missed school because of accident
□ Has not missed school

ACCIDENT DETAILS: Attorney's name:_____ Telephone #:_____

Briefly describe how your accident occurred:

_____
_____
_____
_____

WORK ACCIDENTS AND OTHER TYPES OF INJURIES: Date of Injury____/____/____

In detail, briefly describe when and how your injury occurred:

_____
_____
_____
_____

Insurance Company:_____ Claim #:_____
Insurance Phone Number:_____

IF WORK RELATED:
Employer at time of Injury:_____ Supervisors name:_____
Telephone #:_____
Did you report your injury to your employer? Y N
Did you lose time off from work? Y N
Dates off work: _____/_____/_____ to _____/_____/_____
Did your employer send you to a specific doctor? Y N
Name of the doctor or facility referred to:_____