663 County Road 17, Suite 3
Elkhart, IN 46516

AUTO ACCIDENT FORM

Please fill out the following pages completely and leave no questions unanswered.

Name (Last, First, M.I.) ______________________________ DOB: _______________ Today's Date: _____________

Date of Accident: _____________

What was the cause of the injury? ☐ Automobile vs. Automobile ☐ Automobile vs. Object (non-vehicle)

☐ Motorcycle/Bicycle vs. Vehicle ☐ Motorcycle/Bicycle vs. Object (non-vehicle)

☐ Pedestrian vs. Vehicle ☐ Pedestrian vs. Non-Vehicle

Did the patient contact the interior of the vehicle? ☐ Yes ☐ No

If yes, what part of the body came in contact with the vehicle? (Check all that apply)

☐ Back of head/neck ☐ Front of head ☐ Left side of head ☐ Right side of head

☐ Left chest/flank ☐ Left shoulder ☐ Left arm ☐ Left leg ☐ Left foot ☐ Left knee

☐ Right chest/flank ☐ Right shoulder ☐ Right arm ☐ Right leg ☐ Right foot ☐ Right knee

☐ Other ____

Interior vehicle contact? ☐ Airbag ☐ Armrest ☐ Dashboard ☐ Door ☐ Headrest

☐ Flying object(s) inside vehicle ☐ Seat ☐ Steering wheel ☐ Window

☐ Other ____

Did the patient receive an injury to the head? ☐ Yes ☐ No

Did the patient lose consciousness? ☐ Yes ☐ No

Was the patient the driver or a passenger? ☐ Driver ☐ Passenger

Was the patient wearing a seatbelt? ☐ Yes ☐ No

Did the airbags deploy in the accident? ☐ Yes ☐ No

Which direction was the patient looking at the time of impact during the accident?

____

Patient vehicle impact? ☐ Front right side ☐ Front left side ☐ Front center

☐ Rear right side ☐ Rear left side ☐ Rear end

☐ Right side (passenger side) ☐ Left side (driver side)

Patient vehicle movement? ☐ Backing up ☐ Moving forward ☐ Stopped

☐ Turning left ☐ Turning right ☐ Other ______________________________

How fast was patient vehicle moving? ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐31-40 ☐41-50 ☐51-60 ☐61-70

Patient vehicle damage? ☐ Heavy visible damage ☐ Moderate visible damage ☐ Slight visible damage

☐ No visible damage ☐ Totaled ☐ Other ______________________________

Second vehicle movement? ☐ Backing up ☐ Moving forward ☐ Stopped

☐ Turning left ☐ Turning right ☐ Other ______________________________

How fast was the second vehicle moving?☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐31-40 ☐41-50 ☐51-60 ☐61-70

Second vehicle damage? ☐ Heavy visible damage ☐ Moderate visible damage ☐ Slight visible damage

☐ No visible damage ☐ Totaled ☐ Other ______________________________

Was the patient vehicle towed from the scene? ☐ Was towed ☐ Not towed ☐ Other ________________________

Was EMS (Emergency Medical Services) ☐ Was ☐ Was not ☐ Other ____________________________________

Was the patient taken to the hospital? ☐ Yes ☐ No

If yes, how was the patient transported? ☐ Ambulance ☐ Drove themselves ☐ Family/Friend

☐ Other ____

If yes, which hospital? ____

Did the patient have X-Rays taken? ☐ Yes ☐ No If yes, what areas? ______________________

Describe the discomfort at the time of the accident. Check all that apply. ☐ Aching ☐ Burning ☐ Deep

☐ Diffuse ☐ Dull ☐ Heavy ☐ Intolerable ☐ Pulling ☐ Sharp ☐ Shock-Like

☐ Stabbing ☐ Stiff ☐ Throbbing ☐ Tight ☐ Tingling ☐ Other ________________________

Where were symptoms felt at the time of the accident?

☐ Head ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

☐ Neck ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

☐ Right mid-back ☐ Left mid-back ☐ Central mid-back

☐ Right low back ☐Left low back ☐ Central low back

☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Questions continued on next page

☐ Upper extremity If yes, where specifically? ____

☐ Lower extremity If yes, where specifically? ____

☐ Legs If yes, where specifically? ____

☐ Shoulder If yes, where specifically? ____

☐ Arm If yes, where specifically? ____

☐ Other ____

Additional Symptoms at the time of the accident? (e.g., anxiety, breathing difficulty, disbelief, exhaustion, headache, sore, low energy, rib pain, stomach pain, tiredness) ____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Patient Name: ___________________________ Signature: __________________________ Date: ____________

Parent or Guardian: ______________________ Signature: __________________________ Date: ____________