



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: _____ State Accident occurred in: _____

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 any airbags deploy? Yes No If yes, which airbags? _____

What direction was the patient looking at the time of impact? _____

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

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

If yes, which hospital? _____

Did the patient have X-Rays, MRI or any scans performed? 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.

Cont'd... Where were symptoms felt at the time of the accident?

- 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: _____

If your treatment is being billed to insurance or a lawyer/attorney office, please provide the following information if able.

Claim # or Case #: _____

Bill to (insurance company, attorney, etc): _____

Contact name: _____

Phone number: _____