AUTO ACCIDENT INTAKE FORM

Patient Name: ____ Date:________________

1. Where was the accident located?_________________________ Date____________ Time__________ am / pm

2. How many vehicles were involved in the accent? 1 2 3 4 More

3. What was the estimated damage, in dollars, to the vehicle you were in? $_______________

4. What type of impact was the auto accident?
   - ❏ Rear End ❏ Frontal ❏ Passenger Broadside
   - ❏ Driver Broadside ❏ Other:____

5. How did the accident occur?____

6. What did your vehicle do immediately after the accident?
   - ❏ Hit another vehicle ❏ Spin around ❏ Roll ❏ Other

7. Where were you sitting in the vehicle during the accident?
   - ❏ Driver ❏ Front Passenger
   - ❏ Rear Left Passenger ❏ Rear Right Passenger ❏ Other ____________________________________

8. Did you know the accident was coming? ❏ Unaware ❏ Aware and Relaxed ❏ Aware and Braced

9. What type of vehicle were you in?
   - ❏ Subcompact ❏ Compact ❏ Mid Size ❏ Full Size ❏ Truck
   - ❏ SUV ❏ Minivan ❏ Other_______________________________________

10. What type of vehicle impacted yours?
    - ❏ Subcompact ❏ Compact ❏ Mid Size ❏ Full Size ❏ Truck
    - ❏ SUV ❏ Minivan ❏ Other_______________________________________

11. At the time of impact, was your vehicle moving? ❏ Yes ❏ No
    if yes, how fast? _______ mph, ❏ Slowing ❏ Gaining Speed ❏ Steady

12. At the time of impact, how fast was the other vehicle moving? _______ mph
    ❏ Slowing ❏ Gaining Speed ❏ Steady

13. During and after the crash, what happened to your vehicle? (circle all that apply)
    - ❏ kept going straight
    - ❏ kept going straight hitting a car in front
    - ❏ was hit by another vehicle
    - ❏ spun around
    - ❏ spun around and hit a stationary object
    - ❏ hit a stationary object

14. Did you lose consciousness during the accident? ❑ Yes ❑ No

15. How was your head positioned during the accident? ______________________________

16. Did your head hit anything during the accident? ❑ Yes ❑ No
please describe ______________________________

17. Did your shoulders hit anything during the accident? ❑ Yes ❑ No
please describe ______________________________

18. Did your chest hit anything during the accident? ❑ Yes ❑ No
please describe ______________________________

19. Did your knees hit anything during the accident? ❑ Yes ❑ No
please describe ______________________________

20. What kind of headrest was in your vehicle?
❑ movable fixed headrest ❑ nonmovable fixed headrest ❑ no headrest

21. Did you have your seatbelt on during the accident? ❑ Yes ❑ No ❑ Shoulder Harness
❑ Lap Belt Only
❑ Other

22. Did you go to the hospital?
if no, why (and do not answer 38-43) ______________________________

23. How did you get to the hospital? ______________________________

24. What was the name of the hospital? ______________________________

25. Check what you were prescribed at the hospital
❑ Pain Medication ❑ Muscle Relaxers ❑ Neck Brace ❑ Other

26. Did you receive any stitches for any cuts at the hospital? ❑ Yes ❑ No

27. Were X-rays taken at the hospital? ❑ Yes ❑ No
if yes, which area was taken? ______________________________

28. Have you seen any other physicians or received any treatment? ❑ Yes ❑ No
if yes, describe ______________________________
____

29. Have you missed any work as a result of the accident? ❑ Yes ❑ No How much? ______________

30. Have you ever had any prior similar problems? ❑ Yes ❑ No
if yes, describe ______________________________