Auto Accident Information
Complete Spinal Care & Rehab

Patient Name: _____ **DOB:** _____ **Date**: _____

Accident Information:

Date and Time:_____

Location:_____

Weather: □ Clear □ Cloudy □ Raining □ Snow □ Fog □ Windy

Visibility: □ Daylight □ Dawn □ Dusk □ Dark

Road Conditions: □ Dry □ Wet □ Snow □ Ice □ Mud □ Other

Traffic: □ Heavy □ Medium □ Light □ Other

About the vehicle you were in:

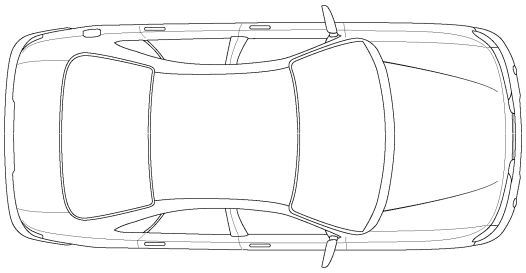
Type:
□ Car
□ Van
□ Pickup Truck
□ Bus
□ Other

Was:
□ Stopped
□ Slowing down
□ Making a turn R/L/U
□ Moving with flow of traffic
□ Other

Was struck by a:
□ Car
□ Van
□ Pickup Truck
□ Bus
□ Other

Was struck in the:
□ Front
□ R front corner
□ R front
□ R middle
□ R rear
□ R rear corner
□ Rear
□ L rear corner
□ L rear
□ L middle
□ L front
□ L front corner

Diagram the damage to your car:



Damage to your vehicle was:
□ None
□ Minimal (<$1000)
□ Significant ($1000-$3000)
□ Extensive (>$4000)

Damage to other vehicle was:
□ None
□ Minimal (<$1000)
□ Significant ($1000-$3000)
□ Extensive (>$4000)

At the time of the accident:

Your position in the car was the:
□ Driver □ Front-seat Passenger □ Rear-seat Passenger

Were you wearing seatbelt: □ Yes □ No

Did your air bag deploy: □ Yes □ No

Were you:
□ Sitting Squarely
□ Twisted
□ Leaning Forward
□ Leaning to the Side
□ Unsure

Your head position was:
□ Faced Forward
□ Turned Left
□ Turned Right
□ Unsure

Were you aware of impending collision: □ Yes □ No

Did you braced for impact: □ Yes □ No

Were you thrown:
□ Forward
□ Backward
□ Side to Side
□ Other
□ None
□ Unsure

Did your head hit the:
□ Steering Wheel
□ Windshield
□ Roof
□ Side window
□ Headrest
□ Air bag
□ None
□ Unsure

After the accident, did you go:

□ Immediately, to the hospital by ambulance
□ Same day, to the hospital using your own transportation
□ Some days later, to the hospital, date: _____
□ To a private physician, date:_____ _____
Name of the hospital/doctor: _____
Any treatment?

Since the Accident (if yes, please explain):

Have you had any accidents/injuries? □ Yes □ No

Anything you've been unable to do? □ Yes □ No

Anything you've difficulty to do? □ Yes □ No

Any changes to your daily activities? □ Yes □ No

Additional Information/Notes: