Patient's Name:	tient's Name: Today's Date:	
Auto Accident Med	chanism of Injury Form	
Date of Collision:		AM / PM
Please describe how the collision happened:		
What was your position in the car? (Circle) <b>Dri</b>	•	ight Rear
If "Driver", were your hands on the steering whee	SI? Both / Left / Right	
Did the airbags deploy? Yes / No		
Did you strike another vehicle? Yes / No	•	
If Second Collision – Angle of 2 <sup>nd</sup> impact: <b>Fron</b>	nt / Back / Left / Right / Other:	
1) In relation to the back of your head, was your I	headrest set: Low / Middle / High	
2) Were you surprised by the impact? Yes / No	•	
If "NO", how did you brace? With Hands /		
3a) Where was your head facing at the time of im		t / Robind
,		. / Bellilla
3b) Were you leaning forward at the time of impa		
4) What type and year of vehicle were you in?		
4a) What was the approximate speed of your veh	nicle when the accident occurred?	mph
5) What type and year of vehicle struck yours?		
5b) What was the approximate speed of the othe	er vehicle when the accident occurred?	mph
6) Were you wearing a seatbelt? Yes / No V	What type: Lap Belt / Shoulder Belt	/ Both
7) Did you feel pain immediately after the accider	nt? Yes / No	
Were you rendered unconscious as a result of the	e accident? Yes / No	
Did you strike anything in the vehicle at the time of your body struck what: (i.e. head, chest, chin, sho		cify what part of
□ Steering Wheel	□ Windshield	
□ Dashboard	□ Roof	
□ Left Side Door	☐ Right Side Door	
□ Left Window	☐ Right Window	
□ Other		
Did your seat break or bend? Yes / No		
Immediately following the accident, how did you fupset / Disoriented / Nervous / Nauseous / Ot		azed / Weak /

Patient's Name:	Today's Date:
Police and Ambulance:	
Was the accident reported to the police? Yes / No	
Were traffic citations issued? Yes / No If "YES", to whom? _	
Did you go to the hospital? Yes / No If "YES", when?	
If "YES", how did you get there?	ivate Transportation
Were you admitted? Yes / No If "YES", how long?	
Name of Hospital? At	tended by Dr
What treatment given? (Circle all that apply) None / X-rays / P	ain Medication / Stitches /
Muscle Relaxants / Bandaged / Cervical Collar / Physical	Therapy / Instructed Regarding
Concussion / Instructed Regarding Sprains & Strains / In	structed to Call an Orthopedist /
Instructed to Call a Private Physician / Referred to This C	office / Other:
What other doctor have you seen as a result of this injury?	
Do you have difficulty in excessive: Standing / Walking / Ridi	ng / Bending / Twisting
Do you have difficulty in excessive lifting: Light / Moderate / F	leavy / Repetitive
Symptoms other than above:	
Patient Signature	Date