

Patient's Name: _____

Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM/PM

Please describe how the collision happened:

What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

Did the airbags deploy? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

Did you car impact with anything other than the other vehicle? **Yes / No (Explain)** _____

Angle of Impact: **Front / Back / Left / Right / Other:** _____

If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other:** _____

1.) In relation to the back of your head, was your headrest set: **Low / Middle / High**

2.) Were you surprised by the impact? **Yes / No**

If "NO", how did you brace? **With Hands / With Feet**

3a.) Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

3b.) Were you leaning forward at the time of impact? **Yes / No**

4a.) What type and year of vehicle were you in? Subcompact car Compact car Full size car

Small Truck Full size Truck Motorcycle Other _____ Year _____

4b.) What was the approximate speed of your vehicle when the accident occurred?

Stopped Slow Moderate Fast

5a.) What type of vehicle struck yours? Subcompact car Compact car Full size car

Small truck Full size truck Motorcycle Other _____ Year _____

5b.) What was the approximate speed of the other vehicle when the accident occurred?

Stopped Slow Moderate Fast

6.) Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

7.) Did you feel pain immediately after the accident? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Windshield
<input type="checkbox"/> Dashboard	<input type="checkbox"/> Roof
<input type="checkbox"/> Left Side Door	<input type="checkbox"/> Right Side Door
<input type="checkbox"/> Left Window	<input type="checkbox"/> Right Window
<input type="checkbox"/> Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:** _____

Since the motor vehicle collision, have you experienced any of the following?

- | | | |
|-------------------------|-----------------|-----------------------------|
| A.) Visual Disturbance | Yes / No | Please explain _____ |
| B.) Dizziness | Yes / No | How often _____ |
| C.) Anxiety | Yes / No | How often _____ |
| D.) Depression | Yes / No | How often _____ |
| E.) Difficulty sleeping | Yes / No | How often _____ |

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? **Ambulance / Police Car / Private Transportation**
 Were you admitted? **Yes / No** If "YES", how long? _____
 Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Anti-inflammatory Medication / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to this office / Other:**

What other doctors or health professionals have you seen as a result of this injury and what care or recommendations did he provide?

Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**
 Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**
 Symptoms other than above: _____

 Patient's Signature

 Date