ADVANCED
SPINE & POSTURE

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AUTO INJURY

Your Name: _____ Today's Date: __ / __ / ____

Date of Collision: __ / __ / ____ Time of Collision: ____ : ____ (circle one) AM PM

What Street, Highway or Intersection & What City & State did the collision occur? _____

_____

Road conditions at the time of collision (Circle One): WET DRY ICY OTHER

Did the police come to the collision scene (Circle One)? YES NO

Is there a report (Circle One)? YES NO Did you request the report (Circle One)? YES NO

Did you go to the hospital (Circle One)? YES NO If yes, what hospital? _____

How did you get to the hospital/who transported you (Circle One)? AMBULANCE SELF SPOUSE FRIEND

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

Did you sustain cuts or bleed as a result of this injury? YES NO If yes, where: _____

Did you sustain bruises from this collision? YES NO If yes, where: _____

Did the airbags deploy? YES NO Where you leaning forward or slumped? YES NO

Where were you seated in the vehicle (Circle One)?

DRIVER FRONT PASSENGER LEFT REAR MIDDLE REAR RIGHT REAR

Were you aware or surprised by the collision (Circle One)? AWARE SURPRISED

Did you strike your head? YES NO

Did you lose consciousness (black out) upon impact (Circle One)? YES NO

If yes, for how long:_____

Did you experience one or more of the following from the collision (Circle all that apply)?

CONFUSED DISORIENTED LIGHTHEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS

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Do you still have any of the above symptoms and if so circle which ones (Circle all that apply)?

CONFUSED DISORIENTED LIGHTHEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS

Are you currently experiencing any of the following as a result of this injury (Circle all that apply):

DIFFICULT CONCENTRATING FATIGUE SLEEPLESSNESS VISION CHANGES HEADACHES

DIFFICULTY WITH MEMORY IRRITABLE ANXIOUS DEPRESSED WEAKNESS

Approx. how long after the collision did you start experiencing pain or discomfort? _____

Was the trunk of your body pointed straight forward at the time of the collision (Circle One)? YES NO

If no, how was it turned? _____

Was you head pointed straight forward (Circle One)? YES NO

If no, what direction was it turned and by how much?_____

How far is the top of the headrest or seat back from the top of your head (approximately):

_____ inches Above _____ inches Below

Were you wearing a seat belt (Circle One)? YES NO

If yes, what type of seatbelt was it (Circle One)? LAP SEATBELT SHOULDER-LAP SEATBELT

Did you receive any injury or bruise from the seat belt (Circle One)? YES NO

On what part of the automobile did your following body parts hit?

Head Hit _____ Chest Hit _____

Right/Left Shoulder Hit _____ Right/Left Arm Hit _____

Right/Left Hip Hit _____ Right/Left Leg Hit _____

Right/Left Knee Hit_____ Other _____

List the year, make and model of the vehicle you were in:

Year_____ Make _____ Model_____

Was your car stopped at the time of impact (Circle One)? YES NO

If yes, was the driver's foot also on the brake (Circle One)? YES NO

If no, then estimate the speed of the vehicle you were in: _____mph

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If your vehicle was moving at the time of impact, was it:

Slowing Down? YES NO Gaining Speed? YES NO

Traveling at a steady rate of speed (Circle One)? YES NO

If YES then describe:_____

What is the estimated cost damage to the vehicle you were in? $ _____

Which of the following car parts broke during this collision (Circle all that apply)?

WINDSHIELD FRONT SEAT BACK RIGHT/LEFT SIDE WINDOW STEERING WHEEL OTHER

What is the year, make and model of the other vehicle?

Year _____ Make _____Model_____

Was the other vehicle moving at the time of the collision (Circle One)? YES NO

If yes, what was its approximate speed? _____mph

If the other vehicle was moving at the time of the collision, was it (Circle One):

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

Was the impact a (Circle one or all that apply):

REAR END DRIVER SIDE IMPACT PASSENGER SIDE IMPACT HEAD ON OBLIQUE ANGLE

SIDE SWIPE ROLL OVER SIDE WAYS ROLL OVER END OVER END

Were you off work as a result of your injuries (Circle One)? YES NO If yes, from _____ to _____

What type of physical effort is required in your line of work? _____

Does your work aggravate your pain (Circle One)? YES NO SOMEWHAT

Please describe, to the best of your knowledge, what happened during the collision:

_____

_____

_____

Have you been in a collision before? If yes, when and what injuries were sustained? _____

_____

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Please draw the collision: