Patient's Name: _____ Today's Date: _____

Auto Accident Mechanism of Injury Form

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

Please describe how the collision happened: _____

_____

_____

_____

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

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**

What was the year, make and model of vehicle were you in? _____

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

What was the year, make and model of the other vehicle? _____

What was the approximate speed of **your vehicle** when the accident occurred? _____ mph

What was the approximate speed of the **other vehicle** when the accident occurred? _____ mph

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

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

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

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

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

Were you surprised by the impact? **Yes** / **No** If "NO", how did you brace? **With Hands** / **With Feet**

Where was your head facing at the time of impact? **Straight Ahead**/ **Left**/ **Right**/ **Behind**/ **Inclined**

Were you leaning forward at the time of impact? **Yes** / **No**

Did you feel pain immediately after the accident? **Yes** / **No** If yes, where? _____

Patient's Name: _____ Today's Date: _____

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.)

□ 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 feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: _____

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** / **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 have you seen as a result of this injury? _____

_____ _____

Patient Signature Date