COLLISION INFORMATION

Riverview Spine: Health and Injury Care

Name: _____Today's Date: _____

Where did the collision occur: Street:_____ City:_____State:_____

Date when collision occurred: _____ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy

Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right

Describe what happened:_____

_____

_____

_____

_____

CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?

❑ Yes ❑ No If passenger, did your hands brace yourself?

❑ Yes ❑ No Did you have your seat belt and shoulder strap on?

❑ Yes ❑ No Was your seat up at the time of impact?

❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?

❑ Yes ❑ No Did the seat belt engage?

❑ Yes ❑ No Did the airbag engage?

❑ Yes ❑ No Did you hit the dash, steering wheel or window?

❑ Yes ❑ No Did you know you were going to be hit?

❑ Yes ❑ No Did you brace yourself with hands or feet?

❑ Yes ❑ No If driving, was your foot on the brake at impact?

❑ Yes ❑ No Was your head turned at impact?

❑ Yes ❑ No Were you leaning forward?

❑ Yes ❑ No Did your glasses fly-off at impact?

❑ Yes ❑ No Was your body turned at the moment of impact?

❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?

❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?

What part of the vehicle was hit? _____

1. What make and model of vehicle were you in?_____ The other vehicle?_____
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? _____
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know?_____

_____

PROVIDERS SEEN

List **all** providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name_____City_____
2. Clinic/Doctor/Hospital Name_____City_____
3. Clinic/Doctor/Hospital Name_____City_____
4. Clinic/Doctor/Hospital Name_____City_____
5. Clinic/Doctor/Hospital Name_____City_____

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?_____

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one:_____

Name of Your Car Insurance Co._____ Your Health Ins. Co. _____

Name of the Other Divers car Insurance if Applicable_____