MOTOR VEHICLE INJURY FORM

General Information

Patient Name: _____

Today's Date: _____

Date of Injury: _____

Employment

Current Occupation: _____

☐ Unemployed

At the Time of Accident: _____

☐ Unemployed

Due to the Accident: ☐ Yes ☐ No

List Any Past Workers' Compensation Injuries:

(Type of Injury/Date/Treatment/Residuals)

_____

_____

_____

List Any Other Personal Injuries:

(Type of Injury/Date/Treatment/Awards/Residuals)

_____

_____

_____

List Any History of Current Complaints:

_____

_____

_____

List Any Treatment by a Chiropractor or Physical Therapist for These Complaints:

_____

_____

_____

Emergency Room

Hospital Name: _____

Date of Arrival: _____

X-Rays Taken: ☐ Yes ☐ No

Body Parts X-Rayed: _____

Lab Work: ☐ Yes ☐ No

Medications Prescribed: _____

Follow Up Instructions: _____

_____

Any Other Doctors Seen for Current Condition:

Name:_____

Name:_____

Accident History

Was the accident when you were working?

☐ Yes ☐ No

You were the: ☐ Driver ☐ Front Passenger

☐ Back Passenger ☐ Motorcycle Operator

☐ Other_____

What was the Driver's Name of Your Vehicle?

_____

Your Vehicle: Year _____ Make _____

Model _____

Other Vehicle: Year _____ Make _____

Model _____

Your Estimated Speed at Time of Accident:_____mph

Was Your Car?

☐ Stopped ☐ Slowing

Accelerating

Were Your Brakes Applied?

☐ Yes ☐ No

Road Conditions at the Time of Accident:

Please Complete Other Side →

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☐ Dry ☐ Damp ☐ Wet ☐ Snow

☐ Ice ☐ Other_____

What is the Estimated Property Damage to Your Vehicle? $_____

What is the Estimated Damage to the Other Vehicle?

☐ Minimal ☐ Moderate ☐ Major ☐ None

Were the Police at the Scene of the Accident?

☐ Yes ☐ No

If Yes, was a Police Report Made?

☐ Yes ☐ No

Briefly Describe the Accident:

_____

_____

_____

_____

_____

_____

_____

Accident Details

Were you aware of the impending crash?

☐ Yes ☐ No

Did you lose consciousness?

☐ Yes ☐ No

If yes, for how long?_____

What kind of headrest is in your vehicle?

☐ Built in ☐ Adjustable ☐ None

What was the position of head rest at time of accident?

☐ Up ☐ Down ☐ Don't Know

Was the position of head rest altered by due to impact?

☐ Yes ☐ No ☐ Don't Know

Was your seat adjustment altered by the accident?

☐ Yes ☐ No

If yes, was your seat broken?

☐ Yes ☐ No

Were you wearing your lap and shoulder seat belt?

☐ Yes ☐ No

Did your airbag deploy?

☐ Yes ☐ No

If Yes, were you struck?

☐ Yes ☐ No

Did you strike any part of the vehicle?

☐ Yes ☐ No

If yes, describe: _____

_____

Did the vehicle strike any object after the crash?

☐ Yes ☐ No

If yes, describe: _____

_____

Were you wearing a hat or glasses?

☐ Yes ☐ No

If yes, were they still on after the crash?

☐ Yes ☐ No

Where were your hands?

☐ One on Wheel ☐ Two on wheel ☐ N/A

How was your body positioned?

☐ Facing Forward ☐ Leaning Forward

☐ Leaning Back ☐ Reaching

How was your head positioned? (Please use degrees)

☐ Forward ☐ Left_____ ☐ Right_____

☐ Up_____ ☐ Down_____

After the Crash

Did you have any of these symptoms?

☐ Headaches

☐ Dizziness

☐ Nausea

☐ Confusion/Disorientation

☐ Neck Pain

☐ Back Pain

☐ Extremity Pain

☐ Tingling or numbness in your arms or legs

Did these symptoms appear immediately after the crash?

☐ Yes ☐ No

If no, how many hours or days later?_____

Where did you go right after the accident?

☐ Home ☐ Work ☐ Hospital

How did you get there?_____

If you have any other pertinent information regarding this injury, please write in the space below.