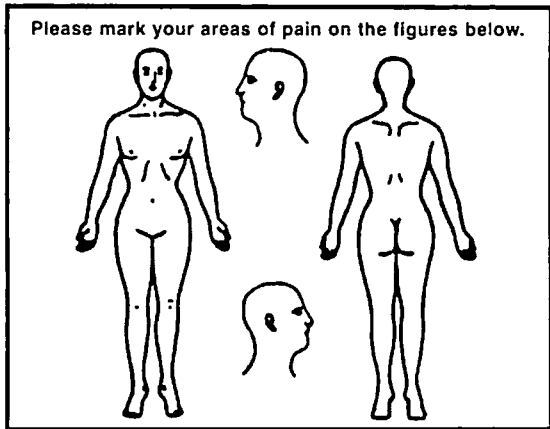


# Automobile Accident

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ Accident Date: \_\_\_\_\_



1. List the conditions that you are most interested in getting corrected. List in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

2. What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## DESCRIBE THE VEHICLE

Location of accident: \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

<b>Patient's Vehicle Type:</b> <input type="checkbox"/> Bus <input type="checkbox"/> Van <input type="checkbox"/> Sport-utility <input type="checkbox"/> Sports car <input type="checkbox"/> Truck <input type="checkbox"/> Coupe <input type="checkbox"/> Station Wagon <input type="checkbox"/> Sedan <input type="checkbox"/> Pick-up truck	<b>Vehicle Size:</b> <input type="checkbox"/> Compact <input type="checkbox"/> Mini <input type="checkbox"/> Full-Size <input type="checkbox"/> Sub-compact <input type="checkbox"/> Light <input type="checkbox"/> Semi <input type="checkbox"/> Mid-Size	<b>Position in vehicle:</b> <input type="checkbox"/> Driver <input type="checkbox"/> Rear left passenger <input type="checkbox"/> Front mid passenger <input type="checkbox"/> Rear mid passenger <input type="checkbox"/> Front right passenger <input type="checkbox"/> Rear right passenger
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## DESCRIBE THE ACCIDENT

<b>Action of patient vehicle:</b> <input type="checkbox"/> Crossing intersection <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped for pedestrian <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Turning right <input type="checkbox"/> Turning left <input type="checkbox"/> Traveling speed limit <input type="checkbox"/> Faster than speed limit <input type="checkbox"/> Slower than speed limit	<b>Patient's Vehicle was hit:</b> <input type="checkbox"/> Head-on <input type="checkbox"/> On the left front <input type="checkbox"/> On the right front <input type="checkbox"/> On the left rear <input type="checkbox"/> On right rear <input type="checkbox"/> Was rear-ended <input type="checkbox"/> Sideswiped on left <input type="checkbox"/> Sideswiped on right	<b>Patient's Vehicle hit:</b> <input type="checkbox"/> Other vehicle head-on <input type="checkbox"/> Left front of other veh. <input type="checkbox"/> Left rear of other veh. <input type="checkbox"/> Rt rear of other veh. <input type="checkbox"/> Rt front of other veh. <input type="checkbox"/> Rear-ended other veh. <input type="checkbox"/> Sideswiped other veh on left <input type="checkbox"/> Sideswiped other veh. on right	<b>Damage:</b> <input type="checkbox"/> Complete <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate  <b>Damage to other Vehicle:</b> <input type="checkbox"/> Complete <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate	<b>Time of Day:</b> <input type="checkbox"/> Dawn <input type="checkbox"/> Daylight <input type="checkbox"/> Dusk <input type="checkbox"/> Night  <b>Visibility</b> <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Good
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<b>Patient's Vehicle was hit by:</b> <input type="checkbox"/> A compact car <input type="checkbox"/> A pick-up truck <input type="checkbox"/> A full-sized car <input type="checkbox"/> A sport-utility veh. <input type="checkbox"/> A mid-sized car <input type="checkbox"/> A full-sized van <input type="checkbox"/> A subcompact car <input type="checkbox"/> A mimi-van <input type="checkbox"/> A semi-trailer <input type="checkbox"/> None of the above <input type="checkbox"/> A light truck <input type="checkbox"/>	<b>Patient's Vehicle hit:</b> <input type="checkbox"/> A compact car <input type="checkbox"/> A pick-up truck <input type="checkbox"/> A full-sized car <input type="checkbox"/> A sport-utility veh. <input type="checkbox"/> A mid-sized car <input type="checkbox"/> A full-sized van <input type="checkbox"/> A subcompact car <input type="checkbox"/> A mimi-van <input type="checkbox"/> A semi-trailer <input type="checkbox"/> None of the above <input type="checkbox"/> A light truck <input type="checkbox"/>	<b>Weather Conditions:</b> <input type="checkbox"/> Clear <input type="checkbox"/> Rainy <input type="checkbox"/> Cloudy <input type="checkbox"/> Snowing <input type="checkbox"/> Drizzling <input type="checkbox"/> Storming <input type="checkbox"/> Foggy <input type="checkbox"/> Sunny <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Road Conditions:</b> <input type="checkbox"/> Dry <input type="checkbox"/> Damp <input type="checkbox"/> Wet <input type="checkbox"/> Iced over <input type="checkbox"/> Dry with icy patches <input type="checkbox"/> Snowed over
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## DESCRIBE MOMENT THE IMPACT

<b>Body Position at impact:</b> <input type="checkbox"/> Leaning forward <input type="checkbox"/> Slouched in seat <input type="checkbox"/> Straight <input type="checkbox"/> Turned left <input type="checkbox"/> Turned right	<b>Head Position at impact:</b> <input type="checkbox"/> Straight <input type="checkbox"/> Titled forward <input type="checkbox"/> Turned left <input type="checkbox"/> Turned right	<b>Type of Passive Restraint:</b> <input type="checkbox"/> Airbag <input type="checkbox"/> Lap belt <input type="checkbox"/> Shoulder belt <input type="checkbox"/> Shoulder-lap belt	<b>Position of Headrests:</b> <input type="checkbox"/> High position <input type="checkbox"/> Low position <input type="checkbox"/> Not installed	<b>Did airbag deploy?</b> <input type="checkbox"/> Deployed <input type="checkbox"/> Did not deployed
<b>Did you brace for impact?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				

<b>Direction body was thrown:</b> <input type="checkbox"/> Forward then back <input type="checkbox"/> To the right <input type="checkbox"/> Outside the vehicle	<b>Direction head was thrown:</b> <input type="checkbox"/> Back then forward <input type="checkbox"/> Forward the back <input type="checkbox"/> Side to side
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Briefly describe how the accident or injury occurred:

\_\_\_\_\_

\_\_\_\_\_

Date last worked: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates lost from due to this injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: \_\_\_\_\_