Automobile Accident Intake Form

Name:_____ **Date of Birth**_____

Date of Accident: _____ **Time of Accident**: _____am/pm □ Daylight □ Dawn □ Dusk □ Dark

List the year, make and model of the car *you* were in: Year_____ Make_____ Model_____

Was the accident on the job? □ Yes □ No **Were you in a company vehicle?** □ Yes □ No

Was your car stopped at the time of impact? □ Yes □ No

If your car was moving at the time of impact was it: □ Slowing Down □ Accelerating □ Going at a Steady Speed

Road Conditions at time of the accident: □ Wet □ Dry □ Snow □ Ice □ Other_____

Did the police come to the accident scene? □ Yes □ No **Is there a police report?** □ Yes □ No

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? □ Aware □ Surprise

Where were you seated in the vehicle? □ Driver □ Passenger □ Rear Seat □ Other_____

Were you wearing a seatbelt? □ Yes □ No If yes, did you receive a bruise or injury from it? □ Yes □ No

Was the seat adjustment altered by the accident? □ Yes □ No Was the seat Broken by the accident? □ Yes □ No

Did the airbag deploy? □ Yes □ No If yes, did it strike you? □ Yes □ No If yes, where? _____

Were you wearing a hat or glasses at the time of impact? □ Yes □ No

If yes, were they still on after the accident? □ Yes □ No

Did your head hit the headrest during the accident? □ Yes □ No

Which way was your head pointing at the point of impact? □ Straight □ Right □ Left □ Other_____

If adjustable, was the position of the headrest altered? □ Yes □ No

How was your body positioned at the point of impact? □ Straight □ Right □ Left □ Other_____

Where were your hands?

_____

Name:_____ Date_____

Did you lose consciousness upon impact? □ Yes □ No
Did you experience a flash of light or explosion in your head? □ Yes □ No
At the time of the accident, did you become or experience any of the following? □ Confused □ Disorientated
□ Light Headed □ Blurred Vision □ Ringing/Buzzing in Ears □ Loss of Balance □ Other_____
Do you still have any of these symptoms? □ Yes □ No Which ones?
_____
Check symptoms you have noticed since the accident:

□ Headaches/Migraines	□ Neck Pain	□ Upper Back Pain	□ Mid Back Pain	□ Shoulder Pain
□ Low Back Pain	□ Depression	□ Buzzing in Ears	□ Arm/Leg Pain	□ Jaw Pain/ Clicking
□ Dizziness	□ Fatigue	□ Loss of Memory	□ Cold Hands/ Feet	□ Numbness/ Tingling
□ Loss of Smell	□ Irritability	□ Digestive Problems	□ Joint Pain/ Stiffness	□ Menstrual Problems
□ Pinched Nerve	□ Loss of Sleep	□ Loss of Balance	□ Chest Pain	□ Light Sensitive Eyes
□ Fever	□ Nervousness	□ Vision Problems	□ Urinary Problems	□ Sleeping Problems
□ Paralysis	□ Tension	□ Fainting	□ Pins/ Needles Feeling	□ Upset Stomach
□ Difficulty Swallowing	□ Sciatica	□ Sinus Pain	□ Sore Muscles	□ Yes □ No
Other:				

Did you go to the Hospital? □ Yes □ No When? □ Immediately □ ____Hours Later □ ____Days Later
Which Hospital? _____ How did you get there? _____ How long did you stay there? _____
What did the Hospital do for your injuries? (collar, splint, x-rays, medication, ect.)
_____
What areas were x-rayed?_____ What was the diagnosis?_____
What did they recommend for follow-up care?
_____
Was any other Doctor consulted after your accident? □ Yes □ No If yes, please complete the information below:
Dr:_____ Specialty:_____ Date First Seen:_____
Type of Treament:_____ Treatment Frequency:_____

Name:_____ Date:_____

List the year, make and model of the *<u>other vehicle</u>*: Year_____ Make_____ Model_____

Was the other vehicle moving at the time of impact? □ Yes □ No If yes, what was the speed of the vehicle? ____mph

If the other car was moving at the time of impact was it: □ Slowing Down □ Accelerating □ Going at a Steady Speed

Please describe to the best of your knowledge what happened during the accident.

_____
_____
_____
_____
_____
_____
_____
_____

You may use the space below to draw the accident.