IF YOU WERE INVOLVED IN AN AUTO TRAUMA, PLEASE FILL OUT THE FOLLOWING:

Patient Name ______________________________ **PT#**______________________

Date of Collision____/____/____ **Location**______________________________

Your auto Insurance Company ____________________ **Claim #**______________ **Phone#**______________

The other persons Insurance Company____________________ **Claim #** ______________ **Phone #**______________

Body Position:
- ☐ Driver
- ☐ Front Passenger
- ☐ Right Rear Passenger
- ☐ Left Rear Passenger
- ☐ Pedestrian
- ☐ Other:

Your vehicle type:
- ☐ Car
- ☐ PU Truck
- ☐ Bus
- ☐ Van
- ☐ SUV
- ☐ Motorcycle
- ☐ Other

What were you doing?
- ☐ Proceeding along
- ☐ Stopped at an intersection
- ☐ Making a left turn
- ☐ Making a right turn
- ☐ Slowing down
- ☐ At a stoplight
- ☐ Parking
- ☐ Stopped in traffic
- ☐ Standing
- ☐ Walking
- ☐ Running
- ☐ Other ______________

Who hit whom?
- ☐ Your vehicle hit them
- ☐ You were hit by another vehicle
- ☐ Double collision
- ☐ Hit by an oncoming vehicle

How were you hit?
- ☐ Rear end
- ☐ Front end
- ☐ Left front
- ☐ Right front
- ☐ Left rear
- ☐ Right rear
- ☐ Other

Road conditions:
- ☐ Icy
- ☐ Snowy
- ☐ Wet
- ☐ Sandy
- ☐ Clear and Dry

Visibility:
- ☐ Poor
- ☐ Fair
- ☐ Good

Time and Speed:
Time of trauma _____ am pm
Date of trauma__________

Your vehicle speed ____**mph**

Their vehicle speed ____ **mph**

Bracing:
Did you see the car coming?
Y N N/A
Were you braced for the impact?
Y N N/A

Head position: ☐ **Looking forward** ☐ **Looking left** ☐ **Looking right**

Were you wearing seat belts?
Y N N/A
Were you wearing a shoulder strap?
Y N N/A

Body Position:
Head position:
- ☐ Looking forward
- ☐ Looking left
- ☐ Looking right

Head rest position
- ☐ Even with the head
- ☐ Above the head
- ☐ At the neck level

Did the airbag deploy?
Y N N/A
Did you plant your feet firmly on the floorboard or brake?
Y N N/A

What did your body hit inside the vehicle?
- ☐ The front seat
- ☐ Steering wheel
- ☐ Side window
- ☐ Windshield
- ☐ Headrest
- ☐ Nothing

Did you…
- ☐ Lose consciousness?
- ☐ See the police?
- ☐ File and accident report?

The Vehicle damage was…
- ☐ Mild ☐ Moderate ☐ Severe
- ☐ <$1500 ☐ $1,500 to $3,500
- ☐ >$3,500 ☐ Totaled

After the accident you went …
- ☐ Home
- ☐ To Hospital
- ☐ To work
- ☐ Other __________

Immediately following the accident you felt…
- ☐ No pain ☐ Mild pain
- ☐ Moderate pain
- ☐ Severe pain

As time passed the problems…
- ☐ Worsened
- ☐ Stayed the same

Did you notice:
- ☐ Bruises
- ☐ Lacerations

What treatment did you receive?
- ☐ Self medicate
- ☐ Prescriptions
- ☐ Used ice or heat
- ☐ None

Work and school:
- ☐ Off work
- ☐ Off work with a note
- ☐ Works in spite of pain
- ☐ Work no problem
- ☐ Unemployed
- ☐ Missed school because of accident
- ☐ Has not missed school

ACCIDENT DETAILS: **Attorney's name:**______________________________ **Telephone #:**____________________

Briefly describe how your accident occurred:

____

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WORK ACCIDENTS AND OTHER TYPES OF INJURIES: **Date of Injury**____/____/____

In detail, briefly describe when and how your injury occurred:

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Insurance Company:______________________________ **Claim #:**______________________
Insurance Phone Number:______________________________

IF WORK RELATED:
Employer at time of Injury:______________________________ **Supervisors name:**____________________
Telephone #:______________________________
Did you report your injury to your employer? Y N **Did your employer send you to a specific doctor? Y N**
Did you lose time off from work? Y N **Name of the doctor or facility referred to:**____________________
Dates off work: ____/____/____ **to** ____/____/____