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CHIROPRACTIC, PHYSICAL THERAPY, SPORTS MEDICINE
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# Automotive Collision Injury Form

## Billing Information

Patient Name:_____

Date of Injury:_____ Time of injury:_____ ☐ AM ☐ PM

City and street where crash occurred: _____

What is the estimated damage to your vehicle? $_____

☐ Yes ☐ No Do you have automobile medical insurance coverage? _____

_____

Name/address/phone _____

_____

What is your car insurance medical coverage limit? $_____

What is the claim number? _____

☐ Yes ☐ No Do you know the claims adjuster's name? _____

☐ Yes ☐ No Have you reported this injury to your car insurance company? _____

☐ Yes ☐ No Did the police come to the accident scene and make a report? _____

☐ Yes ☐ No Is an attorney representing you? Name/address/phone: _____

## Auto Accident Description

**Describe how the crash happened** _____

_____

_____

_____

**Collision Description**

Check all that apply to you:

☐ Single-car crash ☐ Two-vehicle crash ☐ More than three vehicles

☐ Rear-end crash ☐ Side crash ☐ Rollover

☐ Head-on crash ☐ Hit guardrail/tree ☐ Ran off road

**You were the**

☐ Driver ☐ Front passenger ☐ Rear passenger

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**Describe the vehicle you were in**

Model year and make: _____

- ☐ Subcompact car
- ☐ Compact car
- ☐ Mid-sized car
- ☐ Full-sized car
- ☐ Pickup truck
- ☐ Larger than 1-ton vehicle

**Describe the other vehicle**

- ☐ Subcompact car
- ☐ Compact car
- ☐ Mid-sized car
- ☐ Full-sized car
- ☐ Pickup truck
- ☐ Larger than 1-ton vehicle

**Estimated crash speeds**

Estimate how fast your vehicle was moving at time of crash _____ mph

Estimate how fast the other vehicle was moving at time of crash _____ mph

**At the time of impact your vehicle was**

- ☐ Slowing down
- ☐ Stopped
- ☐ Gaining speed
- ☐ Moving at a steady speed

**At the time of impact the other vehicle was**

- ☐ Slowing down
- ☐ Stopped
- ☐ Gaining speed
- ☐ Moving at a steady speed

**During and after the crash, your vehicle**

- ☐ Kept going straight, not hitting anything
- ☐ Kept going straight, hitting car in front
- ☐ Was hit by another vehicle
- ☐ Spun around, not hitting anything
- ☐ Spun around, hitting car in front
- ☐ Spun around, hitting object other than car

**Describe yourself during the crash**

Check only the areas that apply to you:

- ☐ You were unaware of the impending collision.
- ☐ You were aware of the impending crash and braced yourself.
- ☐ Your body, torso, and head were facing straight ahead.
- ☐ You had your head and/or torso turned at the time of collision:
  - ☐ Turned to left
  - ☐ Turned to right
- ☐ You were intoxicated (alcohol) at the time of crash.
- ☐ You were wearing a seat belt.
  - If yes, does your seat belt have a shoulder harness? ☐ Yes ☐ No
- ☐ You were holding onto the steering wheel at the time of impact.

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**Indicate if your body hit something or was hit by any of the following:**
Please draw lines and match the left side to the right side.

| | |
|---|---|
| Head | Windshield |
| Face | Steering wheel |
| Shoulder | Side door |
| Neck | Dashboard |
| Chest | Car frame |
| Hip | Another occupant |
| Knee | Seat |
| Foot | Seat belt |

**Check if any of the following vehicle parts broke, bent, or were damaged in your car**

☐ Windshield ☐ Seat Frame ☐ Knee bolster ☐ Steering Wheel ☐ Side/rear window
☐ Dashboard ☐ Mirror ☐ Other _____ ☐ Other _____

**Rear-end collisions only**
Answer this section only if you were hit from the rear.
Does your vehicle have

☐ Movable head restraints ☐ Fixed, non-movable head restraints ☐ No head restraints

Please indicate how your head restraint was positioned at the time of crash.*

☐ At the top of the back of your head
☐ Midway height of the back of your head
☐ Lower height of the back of your head
☐ Located at the level of your neck
☐ Located at the level of your shoulder blades (upper back) below neck

*Estimate the distance between the back of your head and the front of the head restraints. ____ Inches

**All types of collisions**
Answer this section regardless of the type of crash, indicating those relevant to your case.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Did any of the front or side structures, such as the side door, dashboard, or floor board of your car, dent inward during the crash? |
| ☐ | ☐ | Did the side door touch your body during the crash? |

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Were our hands on the steering wheel or dashboard during the crash? |

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☐ ☐ Did your body slide under the seat belt?

☐ ☐ Was a door of your vehicle damaged to the point where you could not open the door?

**Emergency department**

**Yes** **No**

☐ ☐ Did you go to the emergency department after the accident?

What is name of the emergency department? _____

When did you go (date and time)? _____

☐ ☐ Did you go to the emergency department in an ambulance?

☐ ☐ Did you or another person drive you to the emergency department?

☐ ☐ Where you hospitalized overnight?

☐ ☐ Did the emergency department doctor take X-rays? Check what was taken:

☐ Skull ☐ Neck ☐ Low back ☐ Arm or leg

☐ ☐ Did the emergency department doctor give you pain medications?

☐ ☐ Did the emergency department doctor give you muscle relaxants?

☐ ☐ Did you have any cuts or lacerations?

☐ ☐ Did you require any stitching for cuts?

☐ ☐ Where you given a neck collar or back brace to wear?

**When did you first notice any pain after injury?**

☐ Immediately ☐ Hours after injury ☐ Days after injury

**If you did not see a doctor for the first time within the first week, indicate why**
Check all that apply

☐ No pain was noticed ☐ No appointment schedule available

☐ No transportation ☐ Work/home schedule conflicts

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**If you did not see a doctor for the first time within the first month after injury, indicate why**
Check all that apply

- ☐ No pain was noticed
- ☐ No transportation
- ☐ I thought pain would go away
- ☐ I self-treated with over-the-counter drugs
- ☐ No appointment schedule available
- ☐ Work/home schedule conflict
- ☐ I had no insurance or money
- ☐ I took hot showers, used ice, heat

**Have you been unable to work since injury?**

☐ Yes ☐ No If yes, you were off work ☐ partially or ☐ completely

Please list date off work:_____to_____.