AUTO ACCIDENT INTAKE

Date of accident: _____ First Name: _____ Last Name: _____

Location of accident: _____

Where you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger Make and model of your vehicle:_____ theirs:_____

Was this vehicle equipped with airbags? ☐ Yes ☐ No Did the airbags inflate? ☐ Yes ☐ No Were you wearing a seatbelt? ☐ Yes ☐ No

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right side ☐ Left side ☐Other

In relationship to the base of your skull, where was the headrest? ☐Above ☐Below ☐ At the base

In which direction were you headed? ☐North ☐South ☐East ☐West

Direction the other vehicle was headed? ☐North ☐South ☐East ☐West

During impact, were you facing: ☐Forward ☐Right ☐Left

Did any part of your body strike anything in the vehicle? ☐Yes ☐No Explain: _____

Did the accident render you unconscious? ☐Yes ☐No If yes, for how long? _____

What was the approximate speed of your vehicle? _____ OTHER vehicle? _____

Were you ☐Aware ☐Surprised by the impact

What did your vehicle impact? ☐A Vehicle ☐ Other If other, please explain: _____

# of occupants: _____ List the names of other occupants: _____

_____

In your own words, please describe the accident: _____

_____

_____

Please describe how you felt immediately after the accident: _____

_____

Did the police come to the accident scene? ☐ Yes ☐No Was a police report filed? ☐ Yes ☐No Were there any witnesses? ☐ Yes ☐No

Was a traffic violation issued? ☐ Yes ☐No To whom: _____

Have you retained an attorney? ☐ Yes ☐No If yes, whom? _____ Phone: _____

Have you gone to a hospital or seen any other doctor? ☐ Yes ☐No When did you go? ☐ Immediately ☐Next Day ☐ 2 Days Plus

How did you get there? ☐ Ambulance ☐ Private Transportation Was medication prescribed? ☐ Yes ☐No

Name of the hospital and doctor: _____ Was s/he a: ☐D.D.S ☐M.D. ☐D.C. ☐D.O.

Were any X-rays taken? ☐ Yes ☐No MRI/CT ☐ Yes ☐No

Have you been able to work since this injury? ☐ Yes ☐No Are your work activities restricted as a result of this injury? ☐ Yes ☐No