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AUTO ACCIDENT FORM

Patient Name _____

Today's Date ____/____/____

Accident Details

Date of Accident ____/____/____

- Patient was Located:
- A passenger in the back seat
 - A passenger in the front seat
 - Driver of a motorcycle
 - Other _____
 - The driver with left hand on wheel
 - The driver with right hand on wheel
 - The driver with both hands on the wheel

- Impact Area:
- Driver side
 - Front bumper
 - Front driver side corner
 - Front passenger corner
 - Passenger side
 - Rear bumper
 - Rear driver side corner
 - Rear trailer
 - Rear passenger side corner
 - Totaled and head on collision
 - Other _____

- Headrest Position:
- High
 - Low
 - Middle
 - Unknown

- Lighting Conditions:
- Dawn
 - Dusk
 - Full Daylight
 - Night

- Road Conditions:
- Damp
 - Dry
 - Ice Covered
 - Nasty
 - Snow Covered
 - Wet

- Visibility:
- Excellent
 - Good
 - Fair
 - Poor

Vehicle Info

- Vehicle Status:
- Accelerating
 - At a stop light
 - Attempting to stop
 - Changing Lanes
 - Driving down the road
 - Driving in parking lot
 - Moving
 - Moving at moderate speed
 - Moving at speed limit
 - Moving in reverse
 - Parked
 - Slowing down
 - Speeding
 - Sliding out of control (weather related)
 - Spinning out of control (weather related)
 - Stopped
 - Turning
 - Other _____

Your Vehicle Speed: _____ or Unknown Opposing Vehicle Speed: _____ or Unknown

Opposing Vehicle Type: Compact Car Full Size Car Large Pickup Truck Small Truck

Large SUV Small SUV Motorcycle Semi Other _____

Hospitalization

Admitted: Yes No If **YES**, please answer the questions below.

Admission Time: At time of accident At a later time (explain) _____

Transportation to Hospital: Ambulance Life Flight Police car Private transportation

Doctor: _____ Hospitalized Days: _____ X-rays Taken: Yes No

Additional Notes:

Bracing Status: I was able to brace for impact with my (hands, feet, knees) I was aware that the accident was impending, but unable to brace I was not aware that the accident was impending

Problems: By being thrown from the vehicle By the seatbelt Hit another passenger Hit the back of the front seat Hit the console Hit the dashboard Hit the door Hit the roof of the car Hit the steering wheel Hit the window Hit the windshield Other _____

Injury Locations: Back of Face Back of Head Back of Neck Chest Fingers on Left Hand Fingers on Right Hand Forehead Front of Face Front of Head Front of Neck Left Arm Left Elbow Left Hand Left Hip Left Knee Left Leg Left Shin Left Shoulder Left Wrist Low Back Mid Back Nose Right Arm Right Elbow Right Hand Right Hip Right Knee Right Leg Right Shin Right Shoulder Right Wrist Side of Face Side of Head Side of Neck Upper Back Other _____

Compromised By: Brightness Darkness Fog Rain Snow Traffic

Immediately following the accident, you felt: Angry Disoriented Dizzy Nauseous Nervous Scared Unconscious Upset Other _____