Patient's Name: ____**Today's Date**_________________________

Auto Accident Mechanism of Injury Form

Date of Collision:______________**Hour of Accident:**_____________________**AM/PM**

Please describe how the collusion happened:____
____
____
____

What was your position in the car? (Circle) Driver / Front Passenger / Left Rear / Right Rear

If "Driver", were your hands on the steering wheel? Both / Left / Right

Did the airbags deploy? Yes / No

Did you strike another vehicle? Yes / No Did another vehicle strike your vehicle? Yes / No

Angle of impact: Front / Back / Left / Right / Other:____

If second collision – Angle of 2nd impact: Front / Back / Left / Right / Other:________________________

1) **In relation on the back of your head, was your headrest set: Low / Middle / High**
2) **Were you surprised by the impact? Yes / No**

If "NO", how did you brace? With Hands / With Fee

3(a) Where was your head facing at the time of impact? Straight Ahead / Left / Right / Behind

3(b) Were you leaning forward at the time of impact: Yes / No

4) What type and year of vehicle were you in?____
____

4(a) What was the approximate speed of your vehicle when the accident occurred?____________**Mph**

5) What type and year of vehicle struck yours?____
____

5(a) What was the approximate speed of the vehicle when the accident occurred?__________**Mph**

6) Were you wearing a seatbelt? Yes / No What Type: Lap Belt / Shoulder Belt / Both

7) Did you feel pain immediately after the accident? Yes / No

8) Were you rendered unconscious as a result of the accident? Yes / No

9) Did you strike anything in the vehicle at the time of impact? Yes / No if "YES", specify what part of your body struck what. (i.e. head, chest, chin, shoulder, knee, etc.)

○ **Steering Wheel**	○ **Windshield**
○ **Dashboard**	○ **Roof**
○ **Left Side Door**	○ **Right Side Door**
○ **Left Window**	○ **Right Window**
○ **Other**	

Did your seat break or bend? Yes / No

Immediately following the accident, how did you feel? (Circle all that apply) Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:____
____

Doctor's signature: ________________________

Patients Name:__________________________________Today's Date:____________________________

Police and Ambulance:

Was the accident reported to the police? Yes / No

Were traffic citations issued? Yes / No If "YES", to whom?_____________________________________

Did you go to the hospital or Emergency room? Yes / No If "YES", when?________________________

If "YES", how did you get there? Ambulance / Police / Private Transport

Were you admitted? Yes / No If "YES", how long?____

Name of Hospital?______________________________________Attended by Dr.____________________

What treatment was given? (circle all that apply) None / X-rays / Pain Medication / Stitches / Muscle relaxants / Bandage / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other:____

What other doctor have you seen as a result of this injury?_______________________________________

Do you have difficulty in excessive: Standing / Walking / Riding / Bending / Twisting

Do you have difficulty in excessive lifting: Light / Moderate / Heavy / Repetitive

Symptoms other than above:____