

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type <input type="checkbox"/> Car <input type="checkbox"/> Station Wagon <input type="checkbox"/> Van <input type="checkbox"/> Pickup Truck <input type="checkbox"/> Large Truck <input type="checkbox"/> Bus Other _____ Vehicle type _____ Model Year _____	2. Your position in vehicle <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Left Rear Passenger <input type="checkbox"/> Right Rear Passenger Other _____	3. What was your vehicle doing at the time of the accident? <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Stopped at light <input type="checkbox"/> Making a right turn <input type="checkbox"/> Making a left turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing down <input type="checkbox"/> Accelerating Other _____
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4. Time/Speed/Damage Date of Accident _____ Time of accident _____ am pm Your vehicle's speed _____ mph Their vehicle's speed _____ mph Damage to your vehicle <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled	5. Details of Accident Visibility at time of accident <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Who hit who/what? <input type="checkbox"/> You hit other vehicle <input type="checkbox"/> Other vehicle hit you You hit... (object) _____	6. Road Conditions Road conditions at time of accident <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean and dry Point of impact <input type="checkbox"/> Head-on <input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Rear-end <input type="checkbox"/> Left Rear <input type="checkbox"/> Right Rear <input type="checkbox"/> Roll Over _____ times Other: (Describe) _____
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7. Body Position, etc. Did you see the accident coming? Yes <input type="checkbox"/> <input type="checkbox"/> No Were you braced for the impact? Yes <input type="checkbox"/> <input type="checkbox"/> No Did you have a seat belt on? Yes <input type="checkbox"/> <input type="checkbox"/> No Did you have a shoulder harness on? Yes <input type="checkbox"/> <input type="checkbox"/> No	Does your vehicle have headrests? Yes <input type="checkbox"/> <input type="checkbox"/> No What was the position of your headrest at the time of impact? <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of Neck What was the direction of your head at the time of the impact? <input type="checkbox"/> Facing straight forward <input type="checkbox"/> Turned to the right <input type="checkbox"/> Turned to the left
Did driver side airbags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No Did passenger side airbags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No Did side airbags deploy? Yes <input type="checkbox"/> <input type="checkbox"/> No	

8. Additional accident information (any additional information here that is not covered by the above check offs.)

9. During the accident: Did your body strike the inside of your vehicle? Yes <input type="checkbox"/> <input type="checkbox"/> No If yes, describe _____ Did you lose consciousness during the accident? Yes <input type="checkbox"/> <input type="checkbox"/> No If yes, for how long? _____ Your vehicle's estimated damage? _____ Damage to their vehicle: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled Did the police show up at the scene? Yes <input type="checkbox"/> <input type="checkbox"/> No Was an accident report filled out? Yes <input type="checkbox"/> <input type="checkbox"/> No Who received the citation? _____ What police department wrote the report? Amarillo Police <input type="checkbox"/> TX DPS <input type="checkbox"/> Other _____ Whose vehicle were you in during the accident? My own <input type="checkbox"/> My spouse's <input type="checkbox"/> My parent's <input type="checkbox"/> My friend's <input type="checkbox"/> Other _____ If someone else's car, Name of Owner _____ Who were the occupants in your car (if applicable) _____	10. After the accident: Check off you symptoms right after and a few days following: <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Headache</td> <td><input type="checkbox"/> Mid back pain</td> </tr> <tr> <td><input type="checkbox"/> Neck pain</td> <td><input type="checkbox"/> Low back pain</td> </tr> <tr> <td><input type="checkbox"/> Neck stiffness</td> <td><input type="checkbox"/> Nervousness</td> </tr> <tr> <td><input type="checkbox"/> Fainting</td> <td><input type="checkbox"/> Loss of taste</td> </tr> <tr> <td><input type="checkbox"/> Ringing in ears</td> <td><input type="checkbox"/> Toe numbness</td> </tr> <tr> <td><input type="checkbox"/> Loss of smell</td> <td><input type="checkbox"/> Constipation</td> </tr> <tr> <td><input type="checkbox"/> Pain behind eyes</td> <td><input type="checkbox"/> Cold hands</td> </tr> <tr> <td><input type="checkbox"/> Dizziness</td> <td><input type="checkbox"/> Cold feet</td> </tr> <tr> <td><input type="checkbox"/> Nausea</td> <td><input type="checkbox"/> Diarrhea</td> </tr> <tr> <td><input type="checkbox"/> Confusion</td> <td><input type="checkbox"/> Depression</td> </tr> <tr> <td><input type="checkbox"/> Fatigue</td> <td><input type="checkbox"/> Anxious</td> </tr> <tr> <td><input type="checkbox"/> Tension</td> <td><input type="checkbox"/> Chest Pain</td> </tr> <tr> <td><input type="checkbox"/> Irritability</td> <td><input type="checkbox"/> Sleeping problems</td> </tr> <tr> <td><input type="checkbox"/> Shortness of breath</td> <td><input type="checkbox"/> Incontinence</td> </tr> </table> Others: _____	<input type="checkbox"/> Headache	<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Toe numbness	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Constipation	<input type="checkbox"/> Pain behind eyes	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cold feet	<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Confusion	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Anxious	<input type="checkbox"/> Tension	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Incontinence
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11. Emergency Room?

Where did you go after the accident?
 Home Work Hospital ER Private Doctor
 BSA Nwth Other _____

How did you get there?
 Drove self Ambulance Police Somebody else _____

Were X-rays done? Yes No **Was lab work done?** Yes No

Body parts X-rayed: _____
 What lab work? _____
 The X-rays revealed: _____
 Further tests: _____

Treatments: Cervical Collar Ice **Other:** _____
 Medications: _____
 Follow-up instructions: _____

Have you lost any days from work due to accident? Yes No

If yes, number of days lost _____

12. Treatment History:

Fill in any other doctor(s) seen for this injury prior to your first visit to this office.

1. Dr. _____ **First visit date** ____/____/____
Specialty _____ **X-rays done** Yes No

Types of treatments received: _____

How many treatments received? _____ Currently treating Yes No

Did treatments benefit you? Yes No Last visit date ____/____/____

2. Dr. _____ **First visit date** ____/____/____
Specialty _____ **X-rays done** Yes No

Types of treatments received: _____

How many treatments received? _____ Currently treating Yes No

Did treatments benefit you? Yes No Last visit date ____/____/____

Insurance/Attorney

Your auto insurance company at the time of the accident: _____ **phone or city** _____
Agent _____ **phone or city** _____

Do you have Personal Injury Protection or Medpay on your auto insurance policy? Yes No

Have you filed a PIP/Medpay claim? Yes No **Claim #** _____

Have you been contacted by an adjuster from the other party's insurance company regarding this claim? Yes No

Name of Adjuster _____ **Company** _____
Phone # _____ **Claim #** _____

Check all that apply:

I have settled my personal injury claim with this company
 I have settled the property damage claim (car, etc)
 I have signed an agreement which will pay my medical expenses for a period of time (explain) _____

I have not signed any agreement, nor settled any portion of my claim
 I am currently represented by an attorney
 I am NOT currently represented by an attorney but I wish to retain an attorney

Name of attorney _____ **Phone or city** _____