

Lakeway Spine Center - Auto Accident History

Today's Date: ___/___/___

Patient Name: _____

Date of Accident: ___/___/___

Your Vehicle Type: Small Car Mid-Size Car Full-sized Car SUV Pick-up Other: _____

Other Vehicle Type: Small Car Mid-Size Car Full-sized Car SUV Pick-up Other: _____

I was the: Driver Front Passenger Back Passenger Pedestrian

Were you wearing a seatbelt? Yes No

Did the Airbags deploy? Yes No

Description of Accident: (Check all that apply)

Side-swiped "T-Boned" The other vehicle ran a red light / stop sign.

Which side? Broadside (R L) Front Panel (R L) Back Panel (R L)

Rear-ended by another vehicle while I was:

Stopped for traffic Stopped at red light Stopped at stop sign

Slowing down for traffic/light Slowing down to merge into traffic

Pushed into the vehicle in front of me

Another vehicle hit me head-on

Another vehicle struck the side of my car: Side-swiped "T-Boned"

The other vehicle ran a red light / stop sign.

Which side? Broadside (R L) Front Panel (R L) Back Panel (R L)

I rear-ended another vehicle

I hit another vehicle head-on

I hit the side of another vehicle :

Side-swiped "T-Boned" I ran a red light / stop sign.

Which side? Broadside (R L) Front Panel (R L) Back Panel (R L)

Other: Please describe: _____

Were you aware of the impending impact? Yes No

Were you braced? Yes No

Head Position: Facing forward Looking up Turned right Turned left

Body Position: Facing forward Looking up Turned right Turned left

Did you strike anything in your vehicle? Steering Column Back of seat / headrest Dash

Windshield Door frame Side window Other: _____

Indicate any symptoms you experienced immediately after the impact?

Felt no immediate pain. Pain began later. When? _____

Headache Dizziness Neck pain (R L) Mid-back Pain (R L)

Low back pain (R L) Upper extremity pain (R L) Lower extremity pain (R L)

Other: _____

What did you do after the accident? Went home and rested.

Went about normal business

Went with EMS to Hospital. Which one? _____

Doctored myself

Have you sought other treatment for this accident?

No

My PCP

Who: _____

Other Doctor Who? _____

Specialty _____

What procedures have been performed? None

X-rays MRI / CT Scan

Examination Manipulation / Physical Therapy

Massage Therapy

Prescription: _____

Over-the counter Medication _____