HEALTH + WELLNESS

equilibrium

Auto Accident Intake Form

1. What was the date of the accident?

2. What time did the accident occur?

3. How many vehicles were involved in the accident?

4. What was the estimated damage to the vehicle you were in?

5. What state did the accident occur in?

6. What city did the accident occur in?

7. What street or intersection were you on when the accident occurred?

8. What direction were you traveling in?

9. What type of impact was the auto accident?

10. Did your vehicle hit anything after the accident? If yes, please describe.

11. Where were you sitting in the vehicle during the accident?

12. Did you know the accident was coming?

13. What type of vehicle were you in?

14. What type of vehicle impacted yours?

15. At the time of the impact, how fast was your vehicle moving?

16. At the time of impact, how fast was the other vehicle moving?

17. During and after the crash what happened to your vehicle? (Check all that apply)

- ☐ kept going straight
- ☐ kept going straight hitting a car in front
- ☐ was hit by another vehicle
- ☐ spun around
- ☐ spun around and hit a stationary object
- ☐ hit a stationary object

18. Did you lose consciousness during the accident?

19. How was your head positioned during the accident?

20. How was your torso positioned during the accident?

21. How were your hands positioned during the accident?

22. Did your head hit anything during the accident? If yes, please describe.

23. Did your face hit anything during the accident? If yes, please describe.

24. Did your shoulders hit anything during the accident? If yes, please describe.

25. Did your neck hit anything during the accident? If yes, please describe.

26. Did your chest hit anything during the accident? If yes, please describe.

27. Did your hips hit anything during the accident? If yes, please describe.

28. Did your knees hit anything during the accident? If yes, please describe.

29. Did your feet hit anything during the accident? If yes, please describe.

30. What kind of headrest was in your vehicle?

- ☐ movable fixed headrest
- ☐ non-movable fixed headrest
- ☐ no headrest

31. Where was the headrest positioned on your head?

32. Did you have your seatbelt on during the accident?

33. Did you slide out of your seatbelt during the accident?

34. What was damaged in your vehicle? (Check all that apply)

☐ windshield	☐ rear bumper	☐ mirror	☐ steering wheel
☐ front bumper	☐ knee bolster	☐ dashboard	☐ trunk
☐ back right door	☐ seat frame	☐ front left door	☐ completely totaled
☐ side window	☐ front right door	☐ rear window	☐ back left door

35. Choose the items that dented inward. (Check all that apply)

☐ floorboards	☐ side door	☐ dashboard

36. Choose the doors that would not open as a result of the accident.

☐ front left	☐ front right	☐ rear left	☐ rear right

37. Did you go to the hospital? (If no, why and do not answer 38 – 43)

38. How did get to the hospital?

39. What was the name of the hospital?

40. Were you hospitalized overnight?

41. Circle what you were prescribed at the hospital.

☐ pain medication	☐ muscle relaxer	☐ neck brace

42. Did you receive any stitches for any cuts at the hospital?

43. Were XRAYS taken at the hospital? If yes, which area was taken?