

Patient's Name: _____ **Today's Date:** _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision 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 to 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 Feet**

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

3b) Were you leaning forward at the time of impact? **Yes / No**

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

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

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

5b) What was the approximate speed of the other 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**

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

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.)

<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Windshield
<input type="checkbox"/> Dashboard	<input type="checkbox"/> Roof
<input type="checkbox"/> Left Side Door	<input type="checkbox"/> Right Side Door
<input type="checkbox"/> Left Window	<input type="checkbox"/> Right Window
<input type="checkbox"/> Other	

Did your seat break or bend? **Yes / No**

**Comprehensive Back &
Nutritional Family Care**

Dr. Glen T. Matejka

Patient's Name: _____ **Today's Date:** _____

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

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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? **Yes / No** If "YES", when? _____

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

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

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches /**

Muscle Relaxants / Bandaged / 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: _____

Patient Signature

Date