SYNERGY REHAB AND CHIROPRACTIC, LLC 105 TERRY DR, STE 114

NEWTOWN PA 18940 215.860.9798

AUTO ACCIDENT – 2 PAGES

*PATIENT NAME:*_____*DATE OF BIRTH:*_____

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 occured? _____
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? (circle 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? -yes - no
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? -no - yes, please describe_____
23. Did your face hit anything during the accident? -no - yes, please describe_____
24. Did your shoulders hit anything during the accident? -no - yes, please describe_____
25. Did your neck hit anything during the accident? -no - yes, please describe_____

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26. Did your chest hit anything during the accident? -no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest - nonmovable fixed headrest - no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

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

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

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

35. Choose the items that dented inward
- 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 over night? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxors - neck brace

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

43. Were x rays taken at the hosiptal? If yes, which area was taken?

SIGNATURE OF PATIENT OR GUARDIAN:_____

PRINTED NAME:_____DATE:_____