

Synergy Spine and Injury Center
2500 W. Lake Mary Blvd. Suite 215
Lake Mary, FL 32746
(407) 282-4449 Fax: (407) 282-4438
Noah Herbert, D.C.

Name: _____ Date: _____
Date of Accident: _____ Time of Accident: _____ AM PM
City of Accident: _____ Street of Accident: _____
Road Conditions at the time of the accident: Wet Dry Icy Other _____

Did the police come to the scene of the accident? _____
Did the paramedics come to the scene of the accident? _____
Did you go to a hospital? _____ If "yes", were you taken by ambulance? _____
If you were not taken by ambulance, how did you get to the hospital? _____
If you were taken by ambulance: Were you immobilized? _____
Did the paramedics put you in a neck brace? _____
Did the paramedics put you on a backboard? _____
What services did the first responders perform? _____

What was the name of the hospital to which you were taken? _____
In what city is the hospital located? _____
What procedures were done in the hospital? _____

Were you examined by a specialist? _____ If "yes", what type? _____
What were the recommendations from the emergency room? _____

Were you admitted to the hospital? _____ If "yes", what procedures were done? _____

What type of diagnostic testing was done in the hospital (X-ray, MRI, CT scan, etc.)? _____

The following questions pertain to you, the patient, and the vehicle that you were in:

Were you the driver or a passenger? _____
If you were the passenger where were you seated? _____
Were you wearing a seatbelt? _____ If "yes", did it have a shoulder strap? _____
Did the airbags deploy? _____ If "yes", which airbags? _____
What direction were you looking at the time of impact? _____
Where were your hands at the time of impact? _____
Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? _____
Were you hit at a slow, moderate, or high rate of speed? _____

List the year, make, and model of the vehicle you were in:

Year: _____ Make: _____ Model: _____

List the year, make, and model of the other vehicles involved:

Year: _____ Make: _____ Model: _____

Year: _____ Make: _____ Model: _____

Year: _____ Make: _____ Model: _____

Was your car stopped at the time of accident? _____

If your vehicle was moving at the time of impact, was it slowing down _____; or was it gaining speed _____ at the time of impact?

What was the location of impact? _____

Did you body move after impact? _____ If "yes", which direction? _____

Did you lose consciousness upon impact? _____ If "yes", estimate for how long: _____

Did your head hit any of the following? Steering Wheel _____

Dashboard _____

Windshield _____

Did you receive any lacerations as a result of the accident? _____

Did you receive any bruises or contusions as a result of the accident? _____

Did you receive any physical marks from the seat belt? _____

On what part of the automobile did the following body parts hit:

Head: _____

Chest: _____

Right/Left Shoulder: _____

Right/Left Arm: _____

Right/Left Hand: _____

Right/Left Hip: _____

Right/Left Leg: _____

Right/Left Knee: _____

Right/Left Foot: _____

Other: _____

What was the cost to the vehicle that you were in? _____

Please describe, to the best of your knowledge, what happened during the accident:

If you have been in previous auto accidents, please list the year in which each accident occurred and if you were injured:

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____
- 5.) _____