Synergy Spine and Injury Center

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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.)_____