

Liott Back And Neck Care Center

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

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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
- non movable fixed headrest
- no headrest

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

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

33. Did you slide out of your seat-belt 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 totaled |
| - 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 relaxers - neck brace

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

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

Name: _____ Date: _____