KRAFT CHIROPRACTIC CLINIC

165 West Auburn Road
Rochester Hills, MI 48307

Phone (248) 299-2620
Fax (248) 299-2627

AUTO/WORKER'S COMP INFORMATION

Patient Name: _____

Date of Accident: _____

Insurance Co: _____
(Name)

_____
(Address)

_____
(City, State, Zip)

Phone #: _____

Adjuster: _____

Claim #: _____

(to be filled out by biller)

Coordinated Benefits: Yes No

Billing Address: _____

_____

_____

Additional info:

_____

_____

ACCIDENT / INJURY QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ◯. **Erase** changes cleanly. Do **not fold** form.

A. DATE AND TIME OF ACCIDENT / INJURY

◯ Date: / / Time: : am / pm

B. DESCRIPTION OF ACCIDENT / INJURY

◯ Automobile Crash Questionnaire Marked **(Skip Section B)**
◯ Workmen's Compensation Accident / Injury
◯ Slip/Fall Accident ◯ Pedestrian Accident
Other: ◯ Accident ◯ Injury

1. What was the cause of your accident / injury?

2. Describe in your own words what happened:

C. IMMEDIATELY AFTER ACCIDENT / INJURY

1. Did you lose consciousness?
◯ Yes ◯ No ◯ Don't Know

2. How did you feel?
◯ Confused ◯ Dazed ◯ Dizzy ◯ Nervous
◯ Weak ◯ Other

3. Where did you immediately develop pain?

◯ Head	◯ (R) ◯ (L) Shoulders	◯ (R) ◯ (L) Buttocks
◯ Neck	◯ (R) ◯ (L) Arms	◯ (R) ◯ (L) Hips
◯ Upper / Mid Back	◯ (R) ◯ (L) Elbows	◯ (R) ◯ (L) Thighs
◯ Lower Back	◯ (R) ◯ (L) Forearms	◯ (R) ◯ (L) Knees
◯ Pelvis	◯ (R) ◯ (L) Wrists	◯ (R) ◯ (L) Legs
◯ Chest / Rib Cage	◯ (R) ◯ (L) Hands	◯ (R) ◯ (L) Ankles
◯ Abdomen		◯ (R) ◯ (L) Feet
◯ Other		

4. If there were lacerations (cuts), where were they?

◯ Head	◯ (R) ◯ (L) Shoulders	◯ (R) ◯ (L) Buttocks
◯ Neck	◯ (R) ◯ (L) Arms	◯ (R) ◯ (L) Hips
◯ Upper / Mid Back	◯ (R) ◯ (L) Elbows	◯ (R) ◯ (L) Thighs
◯ Lower Back	◯ (R) ◯ (L) Forearms	◯ (R) ◯ (L) Knees
◯ Pelvis	◯ (R) ◯ (L) Wrists	◯ (R) ◯ (L) Legs
◯ Chest / Rib Cage	◯ (R) ◯ (L) Hands	◯ (R) ◯ (L) Ankles
◯ Abdomen		◯ (R) ◯ (L) Feet
◯ Other		

5. Describe any other significant injury:

6. Emergency Care At Accident/Injury Site
a. Did you receive emergency care? ◯ Yes ◯ No

b. What type of emergency care did you receive?
◯ Bandages ◯ Splints ◯ Brace ◯ Neck Collar
◯ Other

7. Destination After Accident / Injury

a. Where did you go?
◯ Hospital ◯ Home
◯ School ◯ Work
◯ Other

b. By whom were you driven?
◯ Myself ◯ Ambulance
◯ Friend ◯ Family Member
◯ Other

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

1. When did you go to the hospital?
◯ Immediately ◯ Later That Day ◯ Next Day ◯ Days Later
◯ Date / / ◯ Other

◯ Hospital Name:

◯ Examined By Doctor:

Admitted: ◯ Yes ◯ No ◯ Date Discharged: / /

2. If x-rays were taken, of what body part(s)?

◯ Head	◯ (R) ◯ (L) Shoulders	◯ (R) ◯ (L) Buttocks
◯ Neck	◯ (R) ◯ (L) Arms	◯ (R) ◯ (L) Hips
◯ Upper / Mid Back	◯ (R) ◯ (L) Elbows	◯ (R) ◯ (L) Thighs
◯ Lower Back	◯ (R) ◯ (L) Forearms	◯ (R) ◯ (L) Knees
◯ Pelvis	◯ (R) ◯ (L) Wrists	◯ (R) ◯ (L) Legs
◯ Chest / Rib Cage	◯ (R) ◯ (L) Hands	◯ (R) ◯ (L) Ankles
◯ Abdomen		◯ (R) ◯ (L) Feet
◯ Other		

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D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

3. If a CAT Scan was performed, of what body part(s)?

○ Head ○ Upper / Mid Back ○ Chest / Rib Cage
○ Neck ○ Lower Back ○ Abdomen
○ Other

4. If a MRI was performed, of what body part(s)?

○ Head ○ Upper / Mid Back ○ Chest / Rib Cage
○ Neck ○ Lower Back ○ Abdomen
○ Other

5. What was the diagnosis given at the hospital?

a. Head
○ Concussion ○ Skull Fracture ○ Lacerations
○ Contusions ○ Other

b. Jaw
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Whiplash ○ Lacerations
○ Contusions ○ Other

c. Neck
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Whiplash ○ Disc Injury
○ Lacerations ○ Contusions
○ Other

d. Upper / Middle Back
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Disc Injury ○ Lacerations
○ Contusions ○ Other

e. Lower Back
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Disc Injury ○ Lacerations
○ Contusions ○ Other

f. Pelvis
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Lacerations ○ Contusions
○ Other

g. Chest / Rib Cage
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Lacerations ○ Contusions
○ Other

h. Abdomen
○ Strain ○ Lacerations ○ Contusions
○ Other

i. Shoulders
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

j. Arms
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

k. Elbows
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

l. Forearms
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

m. Wrists
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

n. Hands / Fingers
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

o. Buttocks
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Lacerations
○ (R) ○ (L) Contusions ○ (R) ○ (L) Other

p. Hips
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

q. Thighs
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

r. Knees
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

s. Legs
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

t. Ankles
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

u. Feet / Toes
○ (R) ○ (L) Strain ○ (R) ○ (L) Sprain ○ (R) ○ (L) Dislocation
○ (R) ○ (L) Fracture ○ (R) ○ (L) Lacerations ○ (R) ○ (L) Contusions
○ (R) ○ (L) Other

v. Other
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Lacerations ○ Contusions

w. Describe any additional diagnosis given:

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

- ◯ Oral Medication
- ◯ Injection
- ◯ Topical Antiseptics
- ◯ Bandages
- ◯ Sutures
- ◯ Ice Packs
- ◯ Hot Packs
- ◯ Other
- ◯ Splint
- ◯ Cast
- ◯ Brace
- ◯ Collar
- ◯ Support
- ◯ Surgery

7. Instructions Given When Discharged From Hospital

a. Were you told to see?

- ◯ General Practitioner
- ◯ Physical Therapist
- ◯ General Surgeon
- ◯ Other
- ◯ Chiropractor
- ◯ Orthopedist
- ◯ Plastic Surgeon
- ◯ Neurologist
- ◯ Internist

b. What recommendations were made?

- ◯ No Further Care
- ◯ No Follow-up Instructions
- ◯ Observation
- ◯ Rest
- ◯ Ice
- ◯ Heat
- ◯ Collar
- ◯ Support
- ◯ Time Off Work
- ◯ Other

c. Were medications prescribed?

- ◯ Pain
- ◯ Anti-inflammatory
- ◯ Antibiotic
- ◯ Nervousness
- ◯ Other

E. FOLLOWING THE ACCIDENT / INJURY

1. How much later did additional symptoms develop?

- ◯ Immediately
- ◯ Hours
- ◯ That Evening
- ◯ Next Morning
- ◯ Days
- ◯ Week
- ◯ Month

2. What additional symptoms developed?

a. Head

- ◯ Pain
- ◯ Stiffness
- ◯ Numbness
- ◯ Tingling
- ◯ Other

b. Jaw

- ◯ Pain
- ◯ Stiffness
- ◯ Numbness
- ◯ Tingling
- ◯ Other

c. Neck

- ◯ Pain
- ◯ Stiffness
- ◯ Numbness
- ◯ Tingling
- ◯ Other

d. Upper / Middle Back

- ◯ Pain
- ◯ Stiffness
- ◯ Numbness
- ◯ Tingling
- ◯ Other

e. Lower Back

- ◯ Pain
- ◯ Stiffness
- ◯ Numbness
- ◯ Tingling
- ◯ Other

f. Pelvis

- ◯ Pain
- ◯ Stiffness
- ◯ Numbness
- ◯ Tingling
- ◯ Other

g. Chest / Rib Cage

- ◯ Pain
- ◯ Stiffness
- ◯ Numbness
- ◯ Tingling
- ◯ Other

h. Abdomen

- ◯ Pain
- ◯ Stiffness
- ◯ Numbness
- ◯ Tingling
- ◯ Other

i. Shoulders

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

j. Arms

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

k. Elbows

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

l. Forearms

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

m. Wrists

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

n. Hands / Fingers

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

o. Buttocks

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

p. Hips

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

q. Thighs

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

r. Knees

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

s. Legs

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

t. Ankles

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

u. Feet / Toes

- ◯R ◯L Pain
- ◯R ◯L Stiffness
- ◯R ◯L Numbness
- ◯R ◯L Tingling
- ◯R ◯L Other

v. Other ◯

3. Since your accident / injury have you suffered from?

- ◯ Blurred Vision
- ◯ Double Vision
- ◯ Reduced Vision
- ◯ Impaired Hearing
- ◯ Ringing In Ears
- ◯ Chest Pain
- ◯ Difficulty Breathing
- ◯ Palpitations
- ◯ Constipation
- ◯ Diarrhea
- ◯ Nausea
- ◯ Vomiting
- ◯ Frequent Urination
- ◯ Inability To Hold Urine
- ◯ Painful Urination

E. FOLLOWING THE ACCIDENT/INJURY (Continued)

4. Additionally have you experienced any of the following?

- ○ Anxiety
- ○ Convulsions
- ○ Restlessness
- ○ Depression
- ○ Dizziness
- ○ Insomnia
- ○ Mood Swings
- ○ Headaches
- ○ Light Sensitivity
- ○ Nervousness
- ○ Fainting
- ○ Reduced Appetite
- ○ Poor Memory
- ○ Loss Of Balance
- ○ Weakness
- ○ Tension
- ○ Fatigue
- ○ Weight Gain
- ○ Other
- ○ Weight Loss

5. Are you restricted in any of the following areas as a result of this accident/injury?

- ○ Daily Living
- ○ Occupational/Work
- ○ Recreational Activities
- ○ Other

6. Have you missed work due to this accident / injury?

- ○ Missed No Work
- ○ Limited Work Activity
- ○ Missed Work From: / / To: / /
- ○ Other

7. Did you self treat your symptoms?

- ○ Ice
- ○ Heat
- ○ Bed Rest
- ○ Over-The-Counter Medication
- ○ Other

8. Did you seek medical care elsewhere?

a. General Practitioner ○ Name:
○ Diagnosis And Treatment Recommendation:

b. Internist ○ Name:
○ Diagnosis And Treatment Recommendation:

c. Chiropractor ○ Name:
○ Diagnosis And Treatment Recommendation:

d. Neurologist ○ Name:
○ Diagnosis And Treatment Recommendation:

e. Orthopedist ○ Name:
○ Diagnosis And Treatment Recommendation:

f. General Surgeon ○ Name:
○ Diagnosis And Treatment Recommendation:

g. Plastic Surgeon ○ Name:
○ Diagnosis And Treatment Recommendation:

h. Psychologist ○ Name:
○ Diagnosis And Treatment Recommendation:

i. Other ○ Name: ○ Type:
○ Diagnosis And Treatment Recommendation:

9. Have you had any of the following tests?

- ○ CT Scan
- ○ MRI
- ○ Electrodiagnostic Studies
- ○ Other

10. What is the reason for seeking today's consultation?

- ○ Persisting Complaints
- ○ Worsening Of Symptoms
- ○ Other

F. INSURANCE / ATTORNEY INFORMATION

	Yes	No
1. Have you contacted an insurance adjuster or representative regarding this claim? Company: Adjuster: Claim #:	○ Y	○ N
2. Have you engaged services of an attorney? Attorney: Address: City: State: Zip: Phone:	○ Y	○ N
3. Have you filed an accident / injury report?	○ Y	○ N
4. Have you filed for insurance benefits?	○ Y	○ N

NCS Pearson™ forms EW-266182-1:654321

Patient's Or Guardian Signature: **Date:**

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PLEASE MAKE NO MARKS IN THIS AREA

AUTOMOBILE ACCIDENT QUESTIONNAIRE

DR# | PATIENT NUMBER

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

PLEASE USE A NO. 2 PENCIL (ONLY) TO FILL IN APPROPRIATE ANSWERS.
FILL IN BUBBLES COMPLETELY AS INDICATED HERE: ⬭ OR ⬬
ERASE CHANGES CLEANLY. DO NOT FOLD THIS FORM.

PATIENT NAME: _____ **DATE:** _____

A. VEHICLE YOU WERE IN

1. Vehicle type?
○Car ○Pickup ○Van ○Truck ○Station Wagon ○Bus ○Other _____

2. Vehicle size?
○Subcompact ○Full-Size ○Compact ○Mini ○Mid-Size ○Light ○Other _____

3. What was your location in the vehicle?
○Driver ○Front Passenger ○Rear Passenger
Passenger Location: ○Left ○Middle ○Right
○Other _____

4. What was the vehicle you were in doing?
Mark only one bubble for the above question

a. Vehicle stopped for
○Traffic Light ○Intersection ○Stop Sign ○Traffic ○Pedestrian ○Parked ○Other _____

b. Vehicle slowing down for
○Traffic Light ○Intersection ○Stop Sign ○Traffic ○Pedestrian ○Turning ○Parking ○Other _____

c. Vehicle moving
○Slowly ○Moderately ○Fast ○ ____ MPH ○Accelerating ○Other _____

d. Vehicle doing other
○Other _____

5. What damage did the vehicle you were in sustain?
○Minimal ○Moderate ○Extensive ○Totaled ○Unsure ○Other _____

B. IF OTHER VEHICLES INVOLVED IN ACCIDENT

1. First Vehicle To Strike Vehicle You Were In

a. Vehicle type?
○Car ○Pickup ○Van ○Truck ○Station Wagon ○Bus ○Other _____

b. Vehicle size?
○Subcompact ○Full-Size ○Compact ○Mini ○Mid-Size ○Light ○Other _____

c. How did this vehicle strike the vehicle you were in?
○Head On ○From Right ○From Left ○Rear Ended ○Sideswiped On Right ○Sideswiped On Left ○Other _____

d. What damage did this vehicle sustain?
○Minimal ○Moderate ○Extensive ○Totaled ○Unsure ○Other _____

2. Second Vehicle To Strike Vehicle You Were In

a. Vehicle type?
○Car ○Pickup ○Van ○Truck ○Station Wagon ○Bus ○Other _____

b. Vehicle size?
○Subcompact ○Full-Size ○Compact ○Mini ○Mid-Size ○Light ○Other _____

c. How did this vehicle strike the vehicle you were in?
○Head On ○From Right ○From Left ○Rear Ended ○Sideswiped On Right ○Sideswiped On Left ○Other _____

d. What damage did this vehicle sustain?
○Minimal ○Moderate ○Extensive ○Totaled ○Unsure ○Other _____

3. Describe Other Vehicles To Strike Vehicle You Were In
○Vehicle Type: _____ ○How it struck: _____
○Vehicle Size: _____ ○Damage: _____

4. Were traffic citations issued as a result of the accident?
○No Citations issued ○Driver Of Other Vehicle ○Driver Of Vehicle You Were In ○You ○Unsure

C. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?
○Daylight ○Dawn ○Dusk ○Night ○Other _____

2. What was the condition of the road?
○Dry ○Damp ○Wet ○Snow Covered ○Icy ○Other _____

3. Visibility

a. What was the visibility at impact?
○Good ○Fair ○Poor ○Other _____

b. If visibility was poor, why?
○Sun Light ○Darkness ○Rain ○Snow ○Fog ○Traffic ○Other _____

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D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?

- ○ Accident A Complete Surprise
- ○ Aware Of Impending Collision ○ And Braced For Impact

2. Foot On Brake Pedal

a. Was your foot on brake pedal at impact? ○ Yes ○ No

b. Was it knocked off pedal by impact? ○ Yes ○ No

3. Use Of Restraints

a. Restraint Belts

1. Were you wearing a restraint belt? ○ Yes ○ No

2. What type of restraint belt were you wearing?
○ Shoulder-Lap Belt ○ Shoulder Belt ○ Lap Belt

b. Headrests

1. Was vehicle equipped with headrests? ○ Yes ○ No

2. What position was the headrest in?
○ Low ○ Middle ○ High ○ Don't Know

c. Air Bags

1. Was vehicle equipped with air bags?
○ Yes ○ No ○ Unsure

2. Did the air bags deploy? ○ Yes ○ No

4. Your Body

a. What was your body position at impact?
○ Straight ○ Slouched Forward **Rotated:** ○ Right ○ Left
○ Don't Recall ○ Other

b. What direction was your body thrown?
○ Forward\Backward ○ Backward\Forward ○ Sideways
○ Across Vehicle ○ Outside Vehicle ○ Under Vehicle
○ Don't Recall ○ Other

5. Your Head And Neck

a. What position were your head/neck in at impact?
○ Straight ○ Tilted Forward **Rotated:** ○ Right ○ Left
○ Don't Recall ○ Other

b. Through what motion were your head/neck pitched?
○ Forward\Backward ○ Backward\Forward ○ Sideways
○ Don't Recall ○ Other

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?

a. Head

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

b. Right Upper Extremity (Arm)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

c. Left Upper Extremity (Arm)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

d. Torso

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

e. Right Lower Extremity (Leg)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

f. Left Lower Extremity (Leg)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

2. Did your body strike any other objects?

○ Description Of Other Objects Your Body Hit:

F. ADDITIONAL INFORMATION

○ Additional Information About Your Automobile Accident:

Patient's Or Guardian Signature: **Date:**

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