Eastside Chiropractic PA Doctor's Name: David H Mruz, DC

Patient's Name: _____ Today's Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

What was the year, make and model of vehicle were you in? _____

Direction of Impact: **Front / Back / Left / Right / Other**: _____

What was the year, make and model of the other vehicle? _____

What was the approximate speed of **your vehicle** when the accident occurred? _____ mph

What was the approximate speed of the **other vehicle** when the accident occurred? _____ mph

Did the airbags deploy? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other**: _____

In relation to the back of your head, was your headrest set: **Low / Middle / High**

Were you surprised by the impact? **Yes / No** If "NO", how did you brace? **With Hands / With Feet**

Where was your head facing at the time of impact? **Straight Ahead/ Left/ Right/ Behind/ Inclined**

Were you leaning forward at the time of impact? **Yes / No**

Did you feel pain immediately after the accident? **Yes / No** If yes, where? _____

Patient's Name: _____ Today's Date: _____

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:** _____

Police and Ambulance:

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom? _____

Did you go to the hospital? **Yes / No** If "YES", when? _____

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other:** _____

What other doctors have you seen as a result of this injury? _____

_____ _____

Patient Signature Date