Pain & Spine INSTITUTE

Auto Injury

Patient Name:_____

Date of Injury:_____

What body part was injured?

☐Abdomen ☐Ankle ☐Arm ☐Calf ☐Chest ☐Clavicle ☐Elbow ☐Face ☐Foot ☐Groin ☐Hand ☐Head

☐Shoulder ☐Knee ☐Leg ☐Low Back ☐Mid Back ☐Neck ☐Pelvis ☐Wrist ☐Upper Back ☐Hip

☐Sternum ***which side?*** ☐Left Side ☐Right Side ☐Bilateral

Where did the accident occur (Intersection, City, State)?_____

_____

Where was the car hit? ☐Struck from Behind ☐Head On ☐Drivers Side ☐Passenger Side ☐Vehicle Lost Control ☐Other:_____

What was the damage to the vehicle?

☐Minimal ☐Extensive ☐Totaled

Where were you sitting in the car?

☐Driver ☐Front Passenger ☐Rear Seat Drivers Side ☐Rear Seat Passenger side ☐Middle

Did the car rollover? ☐Yes ☐No **Were you wearing a seatbelt?** ☐Yes ☐No

Did the car have an airbag? ☐Yes ☐No **If yes, did the airbag deploy?** ☐Yes ☐No

Did you experience loss of consciousness? ☐Yes ☐No

Was this a Pedestrian vs. Car Injury? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No **If yes, which hospital?**_____

Were you given any pain medication? ☐Yes ☐No **If yes, please list:**_____

_____

_____

Did you seek treatment after the hospital? ☐Yes ☐No **If yes, with whom/where?**_____

_____

_____