



Northwest Chiropractic Clinic P.S Auto Accident Mechanism of Injury Form

Name: _____ Date: _____

Date of Collision: _____ Time: _____

Place: _____

Intersecting with: _____

Police Investigation by:

- Washington State Patrol _____ City Police
 _____ County Police No investigation

Were there any witnesses? Yes No

Please describe, to the best of your knowledge, what happened during this collision:

What is the last thing you remember before the collision? _____

What is the next thing you remember after the collision? _____

What type of car were you in? (year, make, and model) _____

What did your vehicle impact?

- Another vehicle (year, make, model) _____
 Other – explain _____

Road conditions at time of accident: Wet Dry Icy
 Other - Describe: _____

Where were you seated in the vehicle? Driver Front Passenger Rear Passenger



Were you:

- Aware of the approaching collision prior to impact
- Surprised by the impact

Were you wearing a seat belt? Yes No

If yes, what type? Lap belt only Shoulder and lap belt

Did you have any bruising or tenderness on your body in the area of the seatbelt following the collision? Yes No, please describe:

Was your vehicle equipped with headrests? Yes No

If yes, was the top of the headrest:

- Above the base of your skull
- Below the base of your skull

Was the headrest altered or damaged in the collision? Yes No

Did your head go back over the top of the headrest? Yes No Unsure

Is your car equipped with an air bag? Yes No

If yes, did the air bag activate? Yes No

If yes, did you receive any injury from the airbag? Yes No, please describe

Did the impact to your vehicle come from the:

- Front
- Rear
- Right side
- Left side
- Other _____

Was your car stopped at the time of impact? Yes No

If yes, was the driver's foot on the brake? Yes No Don't know

If your foot was on the brake, was it pressing down? Slightly Moderately

Strongly

If no, what was the approximate speed of your vehicle: _____ mph

If your vehicle was moving at the time of impact, was it:

- Slowing down
- Gaining speed
- Steady speed

Was your vehicle pushed forward from the impact? Yes No

If yes, how much?

- More than one car length
- One car length
- One-half car length
- Less than one-half car length
- Not at all



Did your car hit anything else after the first impact? Yes No

If yes, please describe: _____

What is the cost damage to the vehicle you were in? _____

Which of the following car parts broke during the accident?

- a. Windshield _____ d. Front seat back _____
b. Right/Left side window _____ e. Other _____
c. Steering wheel _____ f. Other _____

Was the other vehicle moving at the time of the collision? Yes No

If yes, what was its approximate speed? Approximately _____ mph

If the other vehicle was moving at the time of collision, was it:

- Slowing down Gaining speed Steady speed

What direction was your head pointed at the time of the collision?

- Right Left Forward

What was the position of your hands at the time of the collision?

What was the position of your legs at the time of the collision?

Were you wearing a hat or eyeglasses at the time of the collision? Yes No

What bruises or cuts did you get from this collision? _____

Did any part of your body strike anything in the vehicle? Yes No

A. Head hit _____

B. Chest hit _____

C. Right shoulder hit _____ Left shoulder hit _____

D. Right arm hit _____ Left arm hit _____

E. Right hip hit _____ Left hip hit _____

F. Right leg hit _____ Left leg hit _____

G. Right knee hit _____ Left knee hit _____

H. Other _____



When did you first notice pain or symptoms? _____

Did the collision render you unconscious? Yes No
If yes, for how long? _____ Don't know

Please describe how you felt immediately after the collision: _____

Have you gone to a hospital? Yes No
If yes, when did you go? _____
How did you get there? _____
What parts of your body were x-rayed? _____ None
What treatment did you receive? _____

Have you been treated by any other doctor or health professional? Yes No
If yes, Name _____ City _____
Recommendation and or treatment received _____

How long were you treated? _____

Name _____ City _____
Recommendation and or treatment received _____

How long were you treated? _____

What medication did you take for your injuries? _____
Are you still taking them?
 Yes Do they help? Yes No Don't know
 No How long did you take them? _____
Why did you quit? _____

Have you lost time from work as a result of this injury?
 Yes, give dates: _____
 No

Are your work activities restricted as a result of this injury? Yes No
If yes, describe restrictions _____

