6209 S Old Village Place, Sioux Falls, SD 57108 (605) 271-8277 Beactiveinc.com

Automobile Accident Injury Form

Name: _____

Date of Accident: _____

Describe the accident in your own words: _____

Location of the Vehicle you were sitting? driver front passenger rear right seat rear left seat rear middle

Type of Vehicle (Yours) small car midsize car full size car Small SUV Midsize SUV Large SUV Midsize Truck Large Truck

Type of Vehicle (Other) small car midsize car full size car Small SUV Midsize SUV Large SUV Midsize Truck Large Truck

Seat Belt Worn? □Yes □No **AirBag Deploy?** □Yes □No **Did seat break?** □Yes □No

Head Rest Position? □Low □Middle □High **Did Head Hit Headrest?** □Yes □No **Direction looking at impact?** forward to the right to the left

Did body contact interior? □Yes □No **If Yes, What body part?** _____ **What interior part of vehicle?** _____

Was there head injury? □Yes □No **Was there Loss of Consciousness?** □Yes □No **Duration?** _____

Patient Vehicle Contact? front right front left front center rear right rear left rear center driver side passenger side roll over

Direction Patient Vehicle forward backward stopped turning right turning left

Speed Patient Vehicle ____mph **Did your vehicle impact another vehicle or Structure?** □Yes □No If so, what? _____

Was your foot on brake? □Yes □No **Location of Hands?** _____ **At time of impact** □ Braced □Surprised

Estimated Damage $ _____

Other Vehicle Traveling forward backward stopped turning right turning left

Speed Other Vehicle ____mph Estimated Damage $ _____

Was Police at Scene? □Yes □No Accident Report? □Yes □No Was your vehicle towed? □Yes □No

Was EMS at Scene? □Yes □No Were you taken to ER via EMS? □Yes □No

Were you taken to the ER: □Yes □No Imaging performed? Xray MRI CT Scan None

Treatment you received: _____

Recommended Treatment by ER? _____

Symptoms At Time of Accident:

Stiffness Sharp Discomfort Aching Burning Deep Diffuse Dull Heavy Shock-Like Stabbing Tingling Numbness

Locations of Symptoms At Time of Accident:

Head Face Neck Upper Back Middle Back Ribs Shoulder Abdomin Lower Back Hip Thigh Knee Lower Leg Ankle Foot

Indicate additional symptoms that are a result of this accident:

Additional Complaints Since the Accident:

Anxiety Breathing Difficulties Chest Pains Depression Dizziness Fatigue Genital Pain Gluteal Pain Headaches Irritability Loss Appetite
Low Energy Muscle Spasms Numbness/Tingling Rib Pain Sleep Difficulties Soreness Stomach Pain Stress Upset

Have you been able to work since the injury? □Yes □No

Has work been modified since the injury? □Yes □No

Have you obtained legal council? □Yes □No Name &Firm: _____

SIGNATURE: _____ DATE: _____

Financial

I have reviewed ActiveSpine's Assignment of Insurance Benefits form and agree to its terms

I understand and aware that I am ultimately fiscally responsible for any and all charges incurred with my treatment at ActiveSpine regaurdless of my insurance coverage and/or benefits.

Signature: _____ **Date:** _____