Vehicle Accident Information

Patient Information

Patient Name _____ Date _____

Date of Accident _____ Time of Accident _____ a.m / p.m.

Please describe the accident in your own words: _____

_____

_____

_____

_____

_____

Were you the: ❑ Driver ❑ Rear Passenger ❑ Front Passenger ❑ Pedestrian

How many people were in the accident vehicle? _____

Accident Site

Road / Street Name _____ City / State _____

Nearest intersection with road / street _____ Driving conditions ❑ Dry ❑ Wet ❑ Icy ❑ Other _____

Which direction were you headed? _____ Speed you were traveling? _____

Vehicle

Make & model of vehicle you were in _____

Were you wearing a seatbelt? ❑ Yes ❑ No If yes, what type? ❑ Lap ❑ Shoulder

Was vehicle equipped with airbags? ❑ Yes ❑ No If yes, did it/they inflate properly? ❑ Yes ❑ No

Did your seat have a headrest? ❑ Yes ❑ No If yes, what was the position of the headrest? ❑ Low ❑ Mid-position ❑ High

Other Vehicle

Make & model of other vehicle _____

Which direction was the other vehicle headed? _____ Speed other vehicle was traveling? _____

Impact

Did your car impact another vehicle? ❑ Yes ❑ No

Did your car impact a structure? ❑ Yes ❑ No If yes, explain _____

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No If yes, explain _____

Was impact from: ❑ Front ❑ Rear ❑ Left ❑ Right ❑ Other _____

At the time of impact, were you looking: ❑ Straight ahead ❑ To the left ❑ To the right ❑ Down ❑ Up

Were both hands on the steering wheel? ❑ Yes ❑ No If no, which hand was on the wheel? ❑ Right ❑ Left

Was your foot on the brake? ❑ Yes ❑ No If yes, which foot was on the brake? ❑ Right ❑ Left

Were you: ❑ Surprised by impact ❑ Braced for impact

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Police

Did the Police come to the accident? ❑ Yes ❑ No
Were there any witnesses? ❑ Yes ❑ No
Was a police report filed? ❑ Yes ❑ No
Was a traffic violation issued? ❑ Yes ❑ No If yes, to whom? _____

Patient condition

Were you unconscious immediately after the accident? ❑ Yes ❑ No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

_____

Treatment

Did you go to the hospital? ❑ Yes ❑ No
When did you go? ❑ Immediately after the accident ❑ Next day ❑ 2 days or more after the accident
How did you get to the hospital? ❑ Ambulance ❑ Private transportation
Name of the hospital _____ Name of the Doctor _____

Diagnosis: _____

_____

Treatment received: _____

_____

X-rays taken: _____

Symptoms / Injuries

Have you been able to work since this injury? ❑ Yes ❑ No How many work days have you missed? _____
Prior to the injury were you able to work on an equal basis with others your age? ❑ Yes ❑ No
If you have had any of the following symptoms since your injury, please check the box:

❑ Arm/shoulder pain	❑ Feet/toe numbness	❑ Neck pain
❑ Back pain	❑ Hand/finger numbness	❑ Neck stiff
❑ Back stiffness	❑ Headaches	❑ Shortness of breath
❑ Chest pain	❑ Irritability	❑ Sleep difficulty
❑ Dizziness	❑ Jaw problems	❑ Stomach upset
❑ Ear buzzing	❑ Leg pain	❑ Tension
❑ Ear ringing	❑ Memory loss	❑ Vision blurred
❑ Fatigue	❑ Nausea	

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

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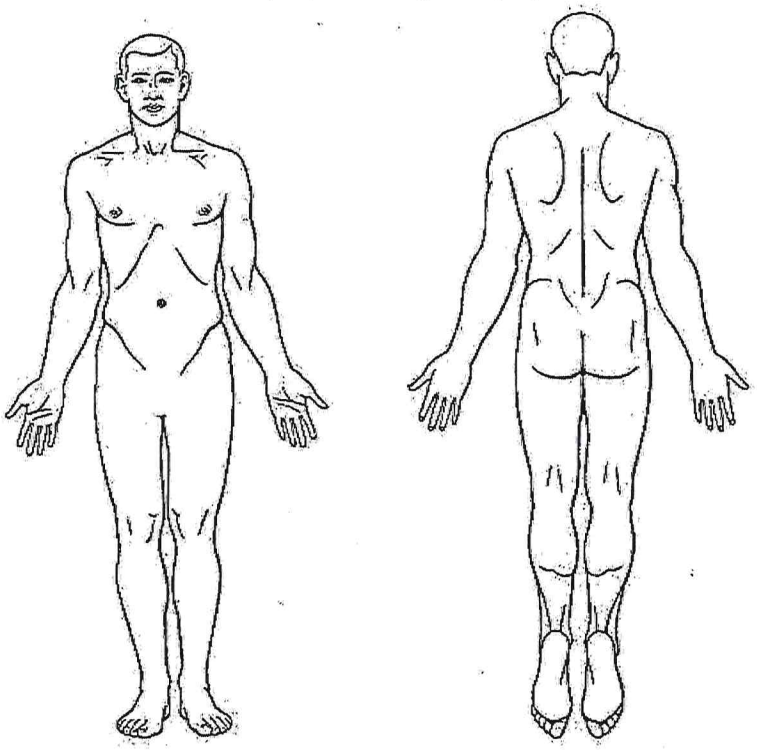
Symptoms / Injuries (continued)

Mark an "x" on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

❑ Sharp	❑ Dull	❑ Throbbing
❑ Numbness	❑ Aching	❑ Shooting
❑ Burning	❑ Tingling	❑ Cramps
❑ Stiffness	❑ Swelling	❑ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

Activities or movements that are painful to perform: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down

I certify that the above information is correct to the best of my knowledge.

_____	_____	_____
Print Name	Signature	Date

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