VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name _____ Date _____

☐AM

Date of Accident _____ Time of Accident _____☐PM

Please describe the accident in your own words: _____

_____

_____

Were you the:

☐ Driver ☐Front Passenger ☐Rear Passenger ☐Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____ City/State _____

Direction you were headed _____ Speed you were traveling _____

Driving Conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other_____

VEHICLE

Make and model of vehicle you were in: _____

Were you wearing a seatbelt?: ☐ Yes ☐ No What type?: ☐ Lap ☐ Shoulder

Was the vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they deploy 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 (if applicable)

Make and model of other vehicle_____

Direction it was traveling _____ Speed it was traveling _____

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

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

Was impact from: Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

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

If yes, please explain _____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking up ☐ Looking down

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

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No If yes, to whom? _____

Were there any witnesses? ☐ Yes ☐ No

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If so, how long _____

Please describe how you felt immediately after the accident: _____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No If yes, 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 hospital_____ Name of doctor _____

Were x-rays taken? ☐ Yes ☐ No Which views?:

☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Other_____

Treatment received _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐Yes ☐No How many days have you missed work? _____

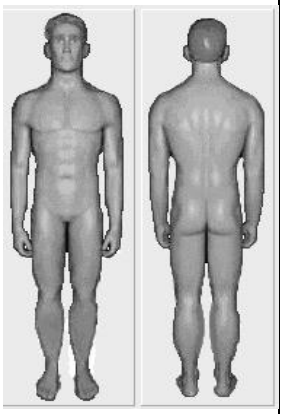
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiffness
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Difficulty sleeping
☐ Dizziness	☐ Jaw problems	☐ Upset stomach/nausea
☐ Buzzing in ears	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Blurred vision
☐ Fatigue	☐ Constipation	☐ Diarrhea

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

Mark an X on the picture where you continue to have pain, numbness, or tingling:



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

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness
☐Shooting ☐Burning ☐Tingling ☐Cramps
☐Aching ☐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

Movements that are painful to perform: ☐Sitting ☐Standing ☐Walking
☐Bending ☐Lying Down

INSURANCE INFORMATION

Name of Patient's Auto Insurance Company _____

Policy # _____ Has a claim been filed with them yet? ☐Yes ☐No

Do you have an attorney that has advised you in this case? ☐Yes ☐No

Attorney Name _____ Phone _____

Address _____

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health.

Patient Signature _____ Date _____