VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

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

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 _____

Nearest intersection with road/street _____

Conditions □ Dry □ Wet □ Icy □ Other_____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and 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 □ Midposition □ High

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 □ Looking to the right

□ Looking to the left □ Looking down

□ Looking 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

OTHER VEHICLE (If Applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? □ 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 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 _____
Diagnosis _____
_____
Treatment received _____
_____
X-rays taken _____

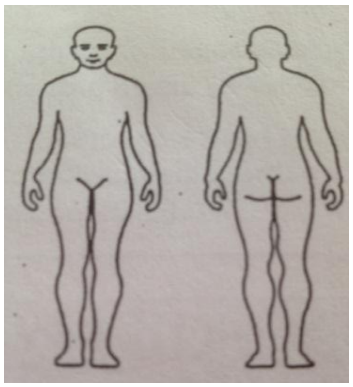
SYMPTOMS/INJURIES

Have you been able to work since this injury? □ Yes □ No How many work days have you missed: _____
Prior to the injury were you albe 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 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
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 Routing □ 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.
Patient Signature _____ Date _____